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Year's End

This issue brings to a close the fortieth volume of the *Journal*. During the past year a wide variety of articles touching on divers topics has been presented; many of them were scholarly expositions on important phases of nursing; some of them might more properly be classified as entertainment, but all were probing into the vast store-house of information waiting to be tapped for the edification of our readers. Your letters tell us that you have found the contents of the hundreds of pages of editorial matter both interesting and instructive. So our first resolve for the new year is to search diligently for the types of material our readers desire and to endeavor to persuade the most capable authors to prepare it for presentation. Suggestions for topics to be developed will be welcomed at all times.

One of the projected plans is to have each month a major topic for which there will be three authors collaborating to bring the medical phases of the disease under discussion, the nursing care from the point of view of the patient in hospital and, to round out the whole picture, the community or public health aspects of the problem. Since every case of serious illness involves so many persons, both in providing care and in making personal adjustments, it will be well to have the broad implications thoroughly discussed.

The second resolve is made with some hesitancy for there are so many factors which are beyond our control. If the late receipt of *The Canadian Nurse* were peculiar to this *Journal*, our concern would be greater. Every publication is experiencing similar difficulties so again your forbearance and understanding is begged. Everything that can be done to speed up delivery is being and will continue to be done.

Finally, to each of our readers we wish a happy, heart-warming Christmas and a successful New Year, brimming with new experiences and spiritual growth.

— M. E. K.

The New Year

A flower unblown; a book unread;
A tree with fruit unharvested;
A path untrod; a house whose rooms
Lack yet the heart's divine perfumes;
A landscape whose wide border lies
In silent shade 'neath silent skies;
A wondrous fountain yet unsealed;
A casket with its gifts concealed—
This is the Year that for you waits
Beyond tomorrow's mystic gates.

HORATIO NELSON POWERS.

Taking Care of Ourselves

Recently, a small boy was heard to remark to a nurse of his acquaintance, "You don't have to take care of yourself, do you? You are a nurse". Both doctors and nurses are reputedly far more careless about their own health practices than are most other groups in the community. Both have far greater knowledge of cause and effect than the average citizen but choose to ignore their own teachings.

This failing is particularly manifest in so far as their application of nutritional knowledge is concerned. Nurses receive instruction in elementary dietetics, in nutrition in relation to disease; they are familiar with the deficiency diseases and the rewards in health and well-being that fall to those who eat balanced meals. But, too often, they cannot be bothered to make the effort either to break away from their old eating habits or to select the nutritious foods they need, and finally end up with undermined health.

Nurses need especially the protective foods of high vitamin content. A high level of general nutrition is urgent since our profession makes heavy demands upon our physical and nervous energy. Nurses, whose hours of duty run continuously through a day of eight to ten hours, are apt to reach a peak of fatigue some time before their work is finished. There would be less weariness and a better job of work accomplished if they gave greater attention to their dietary intake.

It has taken scientists many years to discover and verify these simple facts. How long will it take nurses to learn to apply them personally?

—M.E.K.

Immobilization and Infrequent Dressings in the Treatment of Wounds and Infections

THE LATE GEORGE A. FLEET, M.D. *and* F. DOUGLAS ACKMAN, M.D., C.M., F.R.C.S. (C)

For many years the surgeons attached to our hospital have adopted the closed plaster method in the treatment of compound fractures and have been so pleased with the results that they were encouraged to apply the same procedure to aid them in the cure of osteomyelitis. During the last few years we have found a variety of conditions in which this method has been used to advantage and the field is slowly but surely enlarging.

The material and experience upon which this paper is based has been taken from the surgical wards of the Montreal General Hospital, where interest in the technique advocated herein has been continuous. A very large number of cases of all kinds have been so treated including all varieties of fresh trauma, burns, and infections of all kinds, both aerobic and anaerobic.

Although much has been written in explanation of the success of the occlusive dressing from both investigative and clinical experience, there is still no general agreement. We shall list briefly our observations and opinions with such comment as may be available from experience.

Rest. This fundamental principle of therapy takes precedence over all others factors. It is, moreover, universally understood and accepted. All the other factors will be found to be subordinate to rest in one way or another.

Prevention or limitation of bacterial contamination. There is ample confirmation of the exclusion of pathogenic bacteria from wounds by occlusive dressings. This is exemplified by the "closed plaster" treatment and by the "pressure dressings" as used in burn treatment and plastic surgery. The fact that excessive contamination of wounds by pathogens is the price of frequent change of dressing is also well established. In this connection, the work of Hare, Trueta and Barnes, Orr-Ewing, Scott and Gardner is outstanding. It will also be accepted that the saturation of the dressings with moist discharges contributes to their penetrations by contaminating organisms from bed-clothes, anus, etc. Consequently the thickness and dryness of dressing or plaster are important.

Effect on local circulation.—(*a*) *vascular* (*b*) *lymphatic.* (*a*) The localizing effect on infection of "infrequent occlusive dressings" and in particular, "closed plaster", in so far as the vascular circulation is concerned has been described by Trueta as an active congestion of local tissues under the dressing, in many respects simulating the inflammation phenomena. To the authors, the matter seems more easily understood if pressure is regarded as preventing the accumulation of interstitial fluid and thus, we believe, improving the circulation through the affected part. (*b*) The lymphostatic effect of rest alone has been well demonstrated by Field, White and Drinker. In addition, it should also be recalled that bacterial dissemination from an infection takes place via the lymphatics rather than via the blood stream.

Bacteriostatis.—(*a*) *By autogenous retention within the dressing* of antibacterial and other beneficent products of the body's immunological armamentarium in the exuded serum. It would appear that body defences operate best either early or late when the involved

area is immobilized and contamination prevented by an occlusive dressing.

(*b*) *By chemotherapy*. Fundamentally and principally, this phenomenon arises from natural immunological sources. Many attempts have been made, however, to aid the local natural defensive mechanism of the body by chemotherapy. Such compounds as "Bipp", "Zipp", "Zisp", the aniline dyes, particularly proflavine, and other materials have all been used, and some with considerable success. More recently sulfonamides have been employed in this rôle. This local use of sulfonamides has been widely developed, and they have been combined with other bacteriostatic agents and placed in various vehicles. At the Montreal General Hospital an oil-in-water emulsion of sulfathiazole was devised in 1941 and has now been used for about two years with gratifying results. This emulsion was designed to give both satisfactory curtain drainage and bacteriostasis.

Curtain drainage. Whether in fresh trauma or in pre-infected cases, the rôle of packing gauze in the wound in providing adequate drainage is generally accepted. When paraffin or vaseline is impregnated in the gauze, the usefulness of the drain is increased. This latter fact has been emphasized by several writers, notably by Gurd and McKim, who described it as "curtain drainage".

Adequate surgical treatment. Finally, it should be stated categorically that in compound fractures and in larger wounds, the failure to carry out adequate surgical excision of dead and devitalized tissue, to enlarge the wound, and to relieve fascial tension nullifies all of the foregoing benefits of occlusive infrequent dressings.

Considerable investigation has been carried out to determine if the bacterial flora is reduced in the closed-plaster method of treatment. Unfortunately, that is not so. Trueta found after repeated bacteriological examinations at the surface of the wound and also of the secretions that saturate the plaster, a great abundance and variety of organisms, even in those cases that are most free from clinical symptoms of infection.

It has been proved that almost 100 per cent of accidental wounds are contaminated. Bacteria are carried into the wound by the inflicting agent and thrive on dead tissue or tissue juices. It is during this stage that excision of the wound has proved so valuable. A large proportion of the invading organisms are removed with the excised tissue and foreign bodies.

Fracture treatment. Reduction and fixation of the fractures is now done, and where necessary internal or external mechanical fixation carried out.

Wound (curtain) drainage. From the depths outward the interstices of the wound are now snugly packed with gauze impregnated with 5 per cent sulfathiazole emulsion. The emulsion is used liberally and in excess, rather than conservatively.

Surface dressing. The excess of the packing covers the wound with a thin layer of gauze. This in turn is covered with gauze dressings impregnated with the emulsion. Finally, dry fluffed gauze and cotton waste are used as a reinforcement or padding for the whole area, and in sufficient quantity to make the largest feasible elastic compressible dressing, at least 3 to 4 inches in thickness.

Occlusive dressing. Plaster of Paris, multiple layers of flannelette cut on their bias, elastoplast bandages, or other alternatives are now used to encase the limb or part in such a way as to produce maximum fixation. Not only the wound area but the joints proximal and distal to the wound must be encased. This reduces muscular action to an absolute minimum and consequently promotes lymph stasis. The plaster may be applied as snug moulds or slabs reinforced and

fixed by circular plaster bandages, or the latter may be used throughout. In any event, the encasing plaster or bandages must be applied with moderate pressure. The skill with which this is done allows for sufficient sustained pressure to prevent early loosening, although not sufficient pressure to embarrass the vascular circulation. Such skill will only be acquired by personal experience. It should be pointed out here tnat when starch crinoline bandages are used allowance is made for shrinkage and tightening as the bandage dries. This may appear to vary widely from the unpadded plaster technique. Actually, however, the difference is more apparant than real, for the large elastic dressing under the plaster has essentially the same effect and is, we believe, a safer method for general use. It is noteworthy that Trueta now advocates padding. Drying of the plaster or starch bandage is accelerated by the use of a baker.

Elevation. It is well to allow elevation of the part at least till drying is complete and the circulation well established. During this period frequent inspection of the circulation of the protruding toes or fingers is necessary.

Incisions must be so placed that maximum effect upon interstitial tension may be obtained with minimal damage to essential structures. They must be adequate in size for good drainage purposes. Where necessary Hilton's method of blunt dissection of deeper tissues is employed. As a general rule multiple incisions should be avoided; rather one or a few more extensive openings should be so fashioned that the effect indicated above may be obtained.

All pocketing is broken down and, in carbuncular types of inflammation, the edges of the lesion are undercut to the limit of induration. In every case the guiding rule is to incise sufficiently not only on the surface for good drainage, but, more importantly, to incise the fascial planes so as to both relieve all existing tension and anticipate its possible development or recurrence. Cultures are taken at once. As much necrotic tissue and debris as can be judiciously excised is removed and the purulent contents of the abscess well evacuated. Allowance being made for good drainage, a gauze pack soaked in 5 per cent sulfathiazole emulsion is now placed snugly in the cavity and the ends used to thinly cover the wound. The rest of the dressing procedure is carried out exactly as for fresh trauma wounds.

Dressings are changed with about the same frequency in these cases as in fresh wounds. This may depend somewhat upon the amount of primary haemorrhage, necrosis or exudate, but the weekly timing has for all practical purposes proved satisfactory. This practice is carried out with both indoor and outdoor patients. In many cases, however, as in drained osteomyelitis, it has been found advantageous to leave the cast or dressings on much longer, up to six weeks. So far we have not had cause to regret these longer intervals in a single instance, though the odour may at times become objectionable. The possibility of delay or impairment of function should always be kept in mind after three to four weeks in a fixed position, particularly if for any reason an unphysiological position has been necessary.

Re-dressing — in the normal course of events. When one surveys the reasons for ordinary re-dressing it becomes apparent that the "timing" will vary somewhat with different types of cases, and even with different cases of the same type. The "end point" of the individual dressing has been a consideration of prime importance in this work. In each case all of the above mentioned clinical factors are taken into consideration before reaching a decision. In addition when splinting is not essential, the authors have been influenced by the tissue concentrations of sulfathiazole, and

by the results of daily bacterial counts on the exudate to change the bacteriostatic medium at approximately weekly intervals. It may be of interest to add that this same weekly procedure is carried out on out-patients as well as in-patients.

Temperature. A slight temporary rise of temperature is not an indication to remove or split the cast. In some cases after a change of cast there is temporary increase of temperature which falls to normal in a few days. It is probably due to some extra absorption as a result of handling, or very occasionally to slight fresh infection. Occasionally a continuous increase of temperature results from imperfect immobilization. These temperatures are only transient and unimportant. Persistent increased temperature must be associated with some other symptom before one is justified in removing the cast.

Pain: Continuous throbbing pain, especially if associated with an increased temperature demands investigation. In every single instance persistent pain and fever will be traced to failure of the human factor in either diagnosis or surgical technique, and not to the principle of occlusive dressing.

Edema. Edema of the portion of the extremity beyond the plaster, which persists after elevation of the limb, suggests circulatory trouble. This complication has fortunately been seen very rarely in our cases; apart from the human factor, it may represent secondary haemorrhage or other unforeseen vascular incident.

Loosening of cast. This complication may result from atrophy of the muscles or inadequate improper padding. As one of the main essentials of the treatment, namely immobilization, is lost, the cast must be replaced. Inadequate immobilization such as failure to incorporate nearby joints, may cause any or all of the above mentioned conditions. This point needs all possible emphasis.

Time-limit. There is no such thing as a time-limit in this treatment. Without complications arising, casts have been retained for as long as three months. The average time for a change of cast is about 3 to 4 weeks.

Odour. Offensive odour may occur especially in lower extremity cases. Unless these cases are segregated the other patients in the ward may object strenuously to the odour and force one to change the cast earlier than one anticipated, or to move the patient. Many deodorant devices have been used to obviate this objectional feature of the treatment. A two-layered stockinette "sheath" filled with charcoal and drawn over the plaster has proved satisfactory. Professor Seddon's device of a cloth with absorbent substance incorporated (on a gas-mask filter principle) which is stitched over the plaster has proved quite popular.

Comfort of patient. This is one of the advantages which is beyond argument. The majority of our patients complained of no pain following complete immobilization. In the cases which have been treated by other methods and changed to plaster, the improvement in the patient's mental attitude was a pleasure to behold. In large traumatic wounds or infections it is almost impossible to change dressings without pain. With the closed plaster method the changes are so infrequent that when necessary one can use a general anesthetic without very much harm to the patient.

Saving of material and time of staff. In times like the present with a markedly reduced staff and materials difficult or impossible to obtain, this feature is extremely valuable.

Limitation of infection. There is no doubt that with frequent dressings bacteria new to the wound are introduced at each change. Many cases now are not dressed for 3 to 8 weeks. With these occlusive dressings, new or cross-infection becomes possible only at such in-

frequent intervals and with negligible results. It has been proved experimentally that under conditions of complete immobilization the tissues of the body are capable of resisting many different types of bacteria. It provides the optimal conditions for the body itself to destroy the invaders. There is a strong probability that the majority of bacteria in a localized infection are absorbed into the general circulation by way of the lymphatics. Immobilization of a limb reduces to an almost infinitesimal quantity the flow of lymph. The rate and amount of lymph are both increased by movement of the limb, as shown by Field, White and Drinker.

Hastens healing. In older wounds, granulation tissue acts as a barrier between infected and healthy tissue. It was demonstrated by Halley, Chesney and Dresel in 1927 that this barrier was impermeable to many different varieties of bacteria, provided the granulation tissue presented an unbroken surface. Frequent dressing damages the capillaries, breaks down this barrier and allows the infection to spread.

UNRRA Comes to Canada

ETHEL JOHNS

Before giving a brief report of the UNRRA Conference may I first express my gratitude to the Canadian Nurses Association for appointing me as its representative to the Canadian Council of Voluntary Agencies Assisting UNRRA. It was in this capacity that I had the great privilege of attending the open plenary sessions of the Conference as an observer, a truly unforgettable experience that I should have liked to share at least with the chairman of the Post-war Planning Committee and the president of the Canadian Nurses Association. Unfortunately the strict regulations of the Conference confined the privilege to members of the CCVA.

Montreal has been the scene of many international conferences but none of them has been more significant than the meeting of the Council of the United Nations Relief and Rehabilitation Administration. No Canadian who attended the opening session can ever forget it. We who were privileged to be observers took our places early so that we might miss nothing of that memorable scene.

The green baize tables at which the members of the Council were to be seated were arranged in a horse-shoe, each place marked with the name of the country represented. Behind the chairs of the principal officers there was a magnificent array of massed flags, the banners of the forty-four United Nations. Presently the members of the Council began to drift in almost casually . . . Cuba and the United Kingdom, Costa Rica and China, Ethiopia and Australia, the United States and Greece, Honduras and South Africa. Then they were all there and there was a deep hush.

The fierce Kleig lights were burning full blast and the news-reel cameras stood poised and ready. On the speaker's table there was a battery of microphones and the Canadian Broadcasting Corporation commentator was waiting to go into action. The press completely surrounded the green baize tables. The reading world, the listening world . . . but only a handful of us who actually *saw* it. The one nurse who was there

wished that every nurse in Canada could look over her shoulder.

Then the Director General came in, flanked by two towering Mounties, splendid in their scarlet coats. Two strokes of the gavel and UNRRA was in session. First of all, the Director paid high tribute to Canada. He said that she had been a tower of strength and that no other nation had surpassed her. When Mr. L. B. Pearson, himself a Canadian, took his appointed place as the chairman of the Conference there was tremendous applause and the newsreel cameras moved in for a close-up. His acceptance of this high honour, while modest in tone, showed that he was fully in command of the situation. In fact his opening remark struck the keynote for the whole conference: "The time for action is here".

The vice-chairmen were then presented to the assembly. First the representative of France, young and dark, a noble head and a face lined with suffering. He spoke first in beautiful French, then in English. "I am a soldier of Free France", he said, "now liberated by the Allied Armies. Permit me to express, in the name of the Government of the French Republic, my most grateful thanks". There was a ripple of applause.

The Prime Minister of Canada addressed a subsequent session and was in his happiest vein. As usual, Mr. King quoted poetry . . . Elizabeth Barrett Browning this time, and very much to the point. He was at his best when he was safely off the air and received a tremendous ovation when he spoke with real feeling of those countries whose heroic resistance had purchased the freedom of the whole world. The address of the Director General dealt at some length with the principal accomplishments of UNRRA during recent months and also outlined future objectives. The primary aim is to relieve the military authorities of all concern with civilian problems and needs in the liberated areas at the earliest possible moment. UNRRA works in close cooperation with all agencies native to the area concerned and, in most instances, finds them both ready and willing to strike out for themselves. An extension of activities is now taking place in Russia and in China and the Director General will soon visit Moscow and Chungking. A regional office is to be set up in Sydney, Australia, to handle demands in the Far East.

An entire session was devoted to reports presented by the three Combined Boards with which UNRRA has established relationships. These Boards are concerned with food supply, raw materials, production and resources. The allocation of supplies to the liberated countries appears to be a heart-breaking task but an attempt is made to give help first to those countries which need it most desperately. The breakdown of transportation holds things up all along the line and shortages constitute still another obstacle which is hard to overcome because they are frequently due to unexpected military demands for such diversified commodities as medical supplies and locomotives, shoes and first aid kits, tools and textiles. Interesting changes have come about in the industrial set-up of several countries in the effort to meet these shortages, notably in Great Britain where, for the first time in history, extensive mechanization of the coal mines has taken place.

The discussion of the report of the Director General was held at a closed session from which the press and the observers were excluded. Excerpts were published in the daily bulletin which show that there was some uneasiness regarding a failure to expedite matters as rapidly as had originally been intended. The following quotations indicate the general trend:

Mr. Richard Law, Member of the Council for the United Kingdom:

It is a fact that, in one way or another, the work of UNRRA is being clouded with an atmosphere, a kind of fog, of unreality. UNRRA should seize any opportunity that offers itself to do a practical job of work. Only in that way will UNRRA be able to get the administrative experience and the techniques of administration which will be necessary for it to do the much bigger job that it will face when Germany and Japan have finally collapsed. It seems to me that we should avoid trying to look too far into the future. The future will be taken care of, not by our planning, not by our creating beautiful blueprints; the future will take care of itself if UNRRA is competent to do the job which comes to its hand.

Mr. Dean Acheson, Member of the Council for the United States:

If we turn our eyes forward we see that we are now at a period of action. Whether we like it or not, we must stop planning, we must stop meeting, we must stop talking, and we must act.

By the time the final session was reached it was apparent that these words of warning had been heeded. In his closing address, Mr. Pearson said: "I don't know how it happened, but at this meeting we have come down to earth in a severely practical world. One thing we are doing *now*. We are getting people back to their homes and ways and means have been found to assist that race which, more than any other, has suffered from this war . . . the Jewish people. We have dealt with the problem of extending aid to Italy. We have come to grips at last". When the resolution to extend help to Italy was presented to the Council it was passed unanimously although the representatives of Ethiopia, Greece and Yugoslavia expressed certain reservations. The generosity of these peoples, who had suffered so much at the hands of Italy, aroused great admiration.

It should be kept in mind that UNRRA is essentially a temporary organization which will probably be dissolved within two years after the war ends. Yet it is compelled, here and now, to face up to problems which cannot possibly be solved within the limits of its brief existence. This very fact is perhaps the cause of the delay in what Mr. Pearson calls "coming to grips." Furthermore, UNRRA is primarily a business enterprise and not merely a humanitarian dream. The nations which compose it, Canada included, expect to get as well as give. This prosaic and realistic approach is one of the factors which may well lead to ultimate success. Nevertheless, UNRRA remains one of the greatest experiments in social co-operation of all time. Everyone associated with it, nurses included, must realize that it is a great adventure and that no adventure can be wholly free from an element of risk and the possibility of failure. Perhaps Dr. Kuo has said the last word about UNRRA . . . "It is a hope rather than an achievement, but it is a world community. UNRRA is worthy of the New Age."

Some Facts about UNRRA

WHAT UNRRA IS AND IS NOT:

UNRRA is an international body set up by forty-four member nations, to provide relief and rehabilitation to the people of liberated territories in Europe and the Far East.

UNRRA is *temporary* in function.

and is presumed to terminate with the solving of relief and rehabilitation problems in liberated territories.

UNRRA is not a permanent international organization.

UNRRA operates (1) *during* the military period at the request of the military; (2) *after* the military period at the request of and in agreement with the national authorities of liberated nations.

UNRRA is not the agency of any one government or small group of governments.

UNRRA is not a supra-national organization with powers to relieve and rehabilitate liberated areas solely on its own responsibility.

UNRRA is authorized by the member nations to help distribute short supplies equitably and to help nations to help themselves by getting production of necessities underway again.

UNRRA is not an agency of post-war reconstruction, or concerned with restoration of production facilities other than those needed to meet *immediate* basic needs.

UNRRA is a balancing and equalizing force in the management of relief from *all* sources — allied and other governments, and private relief agencies.

UNRRA is not the *only* source of financing relief, and it was *not* designed to be the only relief agency.

UNRRA is responsible for securing needed experts and technicians to facilitate relief and rehabilitation programs.

UNRRA is not authorized to procure relief supplies for any liberated nation whose government is in a position to pay in foreign exchange.

UNRRA is a claimant agency among many during the war period, and, as such, receives allocations of relief supplies from the total available world supplies through the Combined Boards.

UNRRA procures its allocated supplies through the appropriate agencies of member governments.

UNRRA is concerned with problems of health — undernourishment, infant mortality, communicable diseases, and with assembling stocks of medical supplies, as well as hospital equipment.

UNRRA is responsible for arranging for the temporary care of displaced persons, and their eventual return to their homelands.

UNRRA is concerned with the relief of orphans, aged and handicapped persons, disrupted households, pregnant women, nursng mothers, and similar special cases. Its effort is to help liberated nations re-establish the voluntary and governmental services of their own communities to carry on these humanitarian services.

UNRRA is directed to carry out its relief and rehabilitation program *without discrimination of any kind.*

What UNRRA seeks to deliver to liberated nations qualifying for its services:

Relief supplies: essential consumer goods; food; fuel; clothing, medicines, etc.

Relief services: health and welfare; repatriation of displaced persons, etc.

Rehabilitation supplies and services: seeds, fertilizers; raw materials; machinery; technical services, etc.

Rehabilitation of public utilities and services: light; water; sanitation; power; transportation.

What UNRRA is doing at present

In August, 1944, UNRRA was engaged in a multitude of activities preparatory to carrying its program into effect as soon as the military situation permitted. It was in charge of six refugee camps in the Middle East (some fifty-four thousand persons were being given relief and preliminary self-help training) which UNRRA took over

from MERRA. Arrangements developed with military authorities for providing relief and rehabilitation services in Greece, Yugoslavia, and Albania implemented through the establishment of a Balkan Mission headquarters at Cairo. Machinery for co-operation with the military in other parts of the Mediterranean was also set in operation.

Working relations were being set up with Supreme Headquarters Allied Expeditionary Force (SHAEF) regarding operations in Western Europe, with special emphasis on handling various aspects of the displaced persons problem. A specially-appointed commission of experts had presented a report on health problems of displaced persons in Europe, and a similar commission was appointed to survey and make recommendations concerning health problems arising from unauthorized mass migrations. An expert Commission on Quarantine was constituted by the Subcommittee on Health for Europe and its report on health measures was being studied.

Plans were being carried out to provide special training in the United States for fifty technical experts to be brought from China. Most of the trainees were en route to the U.S.A. for training to develop specific skills in connection with China's relief and rehabilitation program. A special mission despatched to China in the spring of 1944 returned to Washington in the latter part of July after assisting the special committee set up by the Government of China in making a preliminary exploration of relief and rehabilitation needs in China.

On May 1, 1944, the UNRRA Training Centre was established on the campus of the University of Maryland. Personnel recruited in North America were being trained in a four-weeks' intensive course for service overseas. The first major program concentrated on training personnel for service in the Balkans, and consisted of intensive work in Serbo-Croatian and Greek languages, regional study, UNRRA organization and policy, and field procedures. Attending the school were UNRRA employees and members of voluntary agencies co-operating with UNRRA. During July and August, 1944, the average enrolment exceeded one hundred.

To assist the Combined Boards in considering and weighing the requests for allocation of goods to relief purposes, UNRRA was acting as a clearing house, presenting requests on behalf of the nations which would pay for their relief goods out of their own foreign exchange resources. Goods would also be purchased with UNRRA funds and made available to the nations which lacked foreign exchange resources. UNRRA was now procuring supplies of goods which come along seasonally (such as canned fish), or which now existed in good supply but later on would be scarce because the stocks were perishable and must be consumed within a certain time and new production was declining (such as fats). It was also procuring articles which must be manufactured and, therefore, must be arranged for a considerable time in advance of the date of use (such as textiles, footwear, and farm machinery). For the goods which would be in existence either in reserves accumulated for military and lend-lease, or mutual aid purposes, or out of current production at the time in the future when UNRRA wanted to put them on ships and send them to lands needing imports, arrangements were now being made to get hold of the reserves or draw supplies from current production. This included many food items, some hand tools, etc.

UNRRA has made arrangements with more than a score of voluntary welfare and relief agencies (such as American Friends Service Committee, The National Catholic Welfare Conference, The British Red Cross, etc.), to train

experienced and competent relief specialists from the agencies' staffs and incorporate them in UNRRA missions working with the Governments of liberated nations. By September 1, approximately three hundred such voluntary agency members, the top-flight workers in these fields, had been recruited for service in UNRRA missions.

Throughout the spring and summer of 1944 UNRRA's management officials were in daily negotiation with the military theatre commands and the Governments of nations to be liberated, making detailed arrangements for services by UNRRA to the military forces responsible for carrying on civilian relief during the period of military control, and to the civilian Governments which will resume sovereignty over liberated territory after the period of military control. Arrangements were worked out in great detail by September, but could not in all cases be announced.

Unwarranted Segregation

MAJOR S. L. WILLIAMS, R.C.A.M.C.

"And the leper shall put a covering on his upper lip and shall cry: 'Unclean, unclean'." The fear of leprosy, among those not familiar with its characteristics, is almost without parallel. Yet the disease is transmitted with difficulty. It requires intimate contact over a period of many years and even then only a small percentage of contacts acquire the disease.

The communicability of venereal disease is likewise misunderstood. Practically all city and municipal by-laws in Canada contain a clause which states that no person suffering from venereal disease may be employed in the preparation or handling of milk or other foodstuffs. Not long ago a veteran of the South African War lost his job as a dish washer because a routine blood examination revealed a positive test. His infection had been acquired over forty years ago. This is an unjust discrimination. Even in the acute and early stages of venereal infection, casual contact does not transfer these diseases. On a visit to a hospital recently, it was observed that a patient with suspected gonorrheal arthritis and slight urethral discharge had the traditional gown and bowl of disinfectant at the foot of his bed. Such treatment inflicts mental anguish upon patients already suffering psychologically from an acquired venereal disease infection.

Misconceptions regarding the communicability of venereal disease are responsible for these unfair prejudices. Our attitude toward venereal disease has had four distinct phases of development. The ancients deified its acquisition, indicating that the individual was wounded by the dart of Venus and cured by Mercury. In a later period venereal disease was treated casually and frivolously as expressed in the writings of Casanova. During the days of the Puritans the suffering of the venereal disease patient was the wages of sin. Today we are in the period of social legislation — a phase that requires broader horizons and clearer perspective of our concepts of disease and its social implications. Review briefly the emancipation of man from the bonds of superstition and fear that held him throughout the centuries in constant horror and dread of disease.

In the dim dark ages, primitive man was aware of the spread of pestilence and disease. When death decimated their

numbers, it was attributed to the influence of an evil god; when individuals were afflicted it was considered that they were possessed of the devil. The Indian medicine man beat his drums to drive out the evil one; the Chinese built their houses so that the devils would be deflected from their roof tops. As civilization advanced, learned men taught that disease was spread by the stench of filth. They spoke of humors and vapors as the vectors of disease. For example, malaria ravaged those who dwelt in the marsh lands about Rome. It was believed that the foul air in the low-lying districts was the cause of this disease, hence the name Malaria — bad air. The astrologists assigned the signs of the Zodiac to the occurrence of plagues. Many and strange are the theories advanced to account for the factors involved in the spread of disease from the infected person to the healthy individual.

Our present-day concept is based on the scientific proof by Pasteur that germs are responsible for the spread of communicable disease. The advance of medical science has put to rout the misconceptions as chronicled in the medical literature of the past. The parasite of malaria, carried by the mosquito from the patient ill with this disease to the healthy person, is now known to be the cause of this disease. No longer do we believe that malaria is caused by the vapors that arise from the misty marshes. No longer do we believe that the devastating epidemics of typhoid fever were caused by the stench of our cities in that earlier day. We know now that this disease is caused by a germ that is capable of polluting our water and milk supply, if sanitary measures are not taken to avoid the spread of this infection.

Fortunately for humanity, certain germs responsible for disease among us require very special conditions for the transfer of infection from one person to another. Syphilis and gonorrhea are such. They both require moisture and warmth. They both require intimate contact for the transfer of infection. Syphilis and gonorrhea are both transferred to the healthy person by sexual intercourse with an infected person. Since the germs causing syphilis and gonorrhea die almost immediately through drying, this fact limits the possibility of casual transmission of the disease.

In 95 per cent of the cases studied at the Johns Hopkins Hospital, syphilis was transmitted by sexual intercourse. The remaining five per cent of the cases developed as a result of some other personal contact, as for instance, kissing. Dr. Joseph Earle Moore of Johns Hopkins Medical School, an eminent authority on syphilis debunks the risk of accidental infection from household contact, the common drinking cup, eating utensils, clothing, linen, barber shops and beauty parlors. Such infections, if they occur, are so infrequent that they are insignificant.

The patient suffering from venereal disease has a psychological handicap to overcome. In the great majority of cases, there is emotional conflict and personal chastisement because of the sequence of events that led to the exposure and acquisition of infection. He needs help. From a purely behavioristic point of view, he is no different from the individual who, under similar circumstances, exposed himself to infection, but was fortunate enough to escape. Under ordinary nursing conditions, he cannot and will not transfer his infection to you or others. In your own personal experience, do you ever recall the transfer of a specific infection from a patient admitted to hospital with an acute abdominal condition and later diagnosed as acute gonorrheal salpingitis? Nursing care of syphilis and gonorrhea need be no different than the technique used in the management of boils and carbuncles on the surgical wards.

Surely, we should be more considerate and helpful to the patient suffering from venereal disease. To segregate him and treat him as unclean is an injustice. It is not the natural reaction of a profession, in which human sympathy plays such an important part, to jeopardize the best interest of the patient.

That Men May Fly

JEAN WHITEFORD

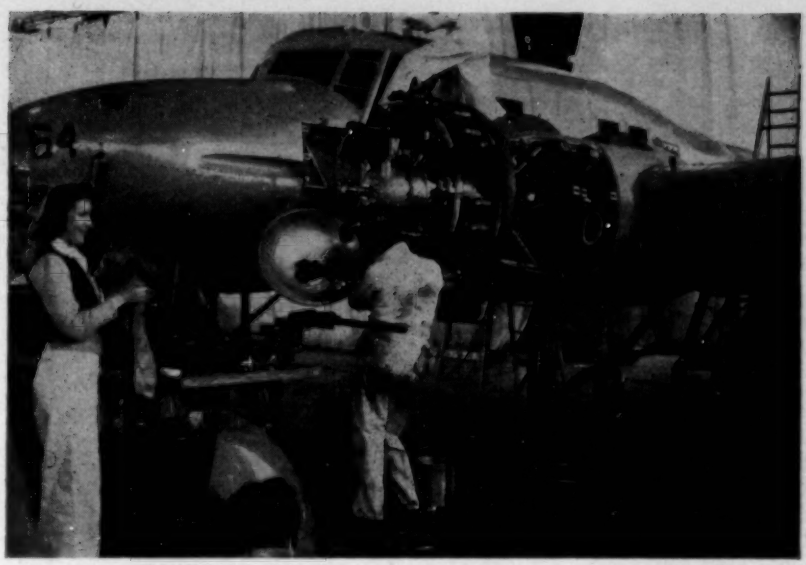
Winnipeg Air Observer School Ltd. is one of several civilian-operated air training schools of the British Commonwealth Air Training Plan, supervised by Canadian Pacific Airlines. Since it was opened some three and a half years ago, it has been fulfilling a very important part in this Plan, by training navigators and air bombers.

The duties of the civilian personnel at this school are many and varied. They range from female and male mechanics making periodic and major checks on aircraft, and fabric workers repairing damaged wings and fuselages, to parachute packers, cleaning, checking and repacking parachutes, to flight clerks logging flying time. The students must be fed and housed — so civilians are busy in the mess and the canteen, as well as keeping the barrack-blocks, classrooms and all buildings and grounds in order and repair. Intricate instruments, including direction finders and drift recorders used during the students' training, require expert handling by specially trained civilian personnel.

Attending a patient.

Summer and winter, night and day, the "flight must go out". Men and girls in coveralls clean, gas and check the aircraft before it is taken over by the civilian pilot. It's cold and windy at midnight on the wings of an aeroplane out in the field, but undaunted the civilians carry on their part in the war effort. They realize that the lives of these young men depend on their integrity and faithfulness to duty.

Management must think in terms of dollars and cents, which means the maximum of efficiency and a more productive war effort. Success is dependent upon the quantity and quality of the man-hours available, and this in turn depends upon the mental and physical health of the individual. The industrial nurse, therefore, has her important part to play in assisting to keep the boys flying, in ensuring as far as she is able that the employees are well and on the job. Management has appreciated how dependent industry is upon healthy employees.



On a repair job.

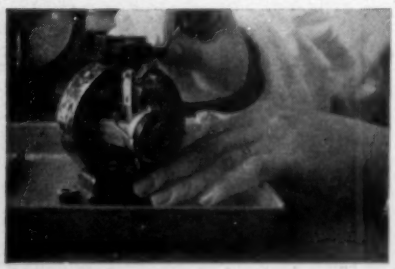
Many of the results of the work of the industrial nurse are not to be found in the company's annual records, nor do they show up in the day by day statistics. The results of her efforts are demonstrated in the increased well-being of those she serves. Like all preventive treatment it is impossible to credit any one type of nursing or any one action for the prevention of accidents or the reduction in sickness, since there are so many contributing factors, but nursing definitely has its part to play.

How far the work of the industrial nurse should encompass the lives of the family of the employee is a debatable subject. From the company's viewpoint, it should only be extended to include the health problems affecting the employee's work, and to cases where the employee requests advice and assistance. From the public health nurse's point of view, it should extend not only as far as is requested but to the limit that may be needed, not only in the interest of the employee but of the community at large. "Johnnie won't eat vegetables. You know his father never eats them and Johnnie copies everything his father does. I don't bother cooking them for myself". How many times have public health nurses heard that from their clients? Some of the responsibility for health teaching surely passes to the industrial nurse, who has an immediate contact with the husband and father. Many an industrial nurse has had the experience of bringing up an employee's baby by remote control. Fathers love to talk about their children, and it has always been a surprise to see their interest in sickness and health. Some time ago a survey was made of employees' eating habits. They recorded their diet, receiving so many points if they drank a pint of milk a day, so many if they ate cereal, vegetables, etc. If they had a well balanced diet they received 100 per cent. The men were by far the most interested in their diet. Our conclusion was that it is the men who drink milk, and according to our reports from our physical examinations it is the girls who pay the dentist.

Through the assistance of the management the nurse was able to organize a girls' council. This group, representing all departments, arranged for the showing of films on tuberculosis, and utilized posters and booklets as part of a very well-prepared advance publicity program. The Anti-tuberculosis League set up their equipment in one of the hangars and for four days they x-rayed the employees on microfilm. This was received exceptionally well by both the management and the employees.

The girls' council also sponsored a campaign for blood donors. It was found that quite a number were unable to give blood because of low hemoglobin. These were seen by the nurse and advised to consult their own doctor if necessary. They were given advice as to diet and other habits. A high iron diet list with instructions was given them to take home to be used as a guide in meal planning. There has been a great deal of interest shown in this program and satisfactory results have been obtained.

Demonstrations were another part of the girls' council activity last winter. The first one was put on by The Hudson's Bay Co. in the form of a fashion show. Five models and a commentator brought some twenty costumes out to the plant. Emphasis was placed on posture, grooming and personal daintiness. A skit on posture with timely comments from the commentator taught posture, showing it's bearing on health and personality. This application was far more effective than any amount of talking. "Beauty is Your Duty" by the T. Eaton Co., utilizing the slogan "Drink Milk for Beauty", and "Beauty Comes from Within" was very well received. "Remake Review" and "Glove Making", by the Extension Department of the University of Manitoba, again pointed out the effect of appearance and was most beneficial and interesting.



Making delicate adjustments.

Part of the summer program has been education of the girls regarding venereal disease. We were fortunate in being able to obtain two films for the entire summer, as well as a good supply of posters and booklets. On rainy days when "flying is washed" the management gave the girls permission to spend an hour with the nurse. We have been able to take small crews of girls and give them a short talk, show them the films, and follow it with a discussion. Miss M. Delamater, R.N. is in our Health Centre and she follows up with a Wassermann test when the employee requests it.

The Health Centre is a very busy place. All minor injuries and illnesses are treated by the nurse, according to standing orders which have been received from the station doctor. If any serious injury occurs or ailments are discovered, the employee is attended by the company doctor or his own physician and treatments are given by the nurse under the doctor's direction. Accidents are recorded, studied and, if possible, interpreted as to the cause, and how it could have been prevented. The first month the Health Centre was open thirteen girls reported ankle and foot trouble. The roads were new and were covered with loose gravel, which was unavoidable at the time. The histories showed that most of the girls had high heels on at the time of their accident. Memos were sent out to all bulletin boards drawing this to the girls' attention, and advising low heels and well fit-

ting shoes. The number of complaints was reduced considerably as soon as this advice was taken.

A meat slicer was the cause of two girls cutting their hands in one week. One had to have four stitches put in the wound. Since the cause was carelessness due to hurrying, the problem was discussed with the canteen manager and a very impressive poster showing how the accident happened was placed beside the meat slicer. The manager rearranged duties so that the waitresses would not be using the meat slicer during the very busy period.

As all the employees are on a month's probation before they are taken on the permanent staff they were given a complete physical examination by the R.C.A.F. medical officer. The findings were recorded and the employee advised as to the best method of correcting the defects or deficiencies.

During the hot weather salt tablets are placed beside the drinking fountains. The employees state they notice a lessening in their feeling of fatigue after they have taken them.

To see things through the employee's eyes is very difficult for the average nurse. Accordingly in an effort to gain their view point, the nurse went in coveralls into each of the departments for a day or part of a day and participated in the work going on there. Would she lose prestige? Would the employee see how dumb she was? Would they help her to understand their jobs? These questions were in her mind as she pulled on the bulky coveralls and tied a kerchief around her head. She almost turned back as the boys gave the usual whistle that is given all new girls, but when she looked back she realized that that was her "acceptance check", and it helped to make her one of them. The fact that her face got dirty and that she went to the canteen with the crew at smoking time also helped. After the novelty wore off, there was real interest

Protection from harmful dusts.

shown by the employees. The fact that she got sleepy at 3 a.m. just the way they did when they worked the graveyard shift, and that her back got tired just as theirs did when they first started hooking up the towbar, made for a feeling of "now you understand". It was a real satisfaction to see the employees' pride in showing how metal is drilled, and how well they could do it when demonstrating to the nurse. In discussing her findings with the foreman and department managers and hearing comments that reached her via the grapevine, we have felt that it was very much worthwhile. Now, the girl who says that her job is too heavy can't say that with such emphasis when she looks at the nurse's five feet and half an inch as she says "Well, I did it". We have tried to check the weight of any heavy jobs, such as the weight of the towbar, to be sure that the average girl is not lifting more than she should. The complaints about the discomfort from wearing masks were reduced also, after the masks

were checked by the Department of Industrial Hygiene, and worn by the nurse for a day.

Another important method of understanding the why and wherefore of poor workmanship is through visiting the homes of the girls. This is done by the nurse and the information received is invaluable in assisting the department manager to understand their personnel. City social service and public health agencies are contacted when it seems advisable, in the interests of the employee. Records are kept and employee's reasons for being absent, whether illness or other causes, are noted. A report is sent in writing to the department manager or the case is discussed with him if that seems a wiser course.

We have inaugurated a definite policy for cases of dysmenorrhea. If a girl is a regular offender she is required to bring the nurse a letter from her doctor stating that no further treatment is advised by him, and it may be necessary for her to be absent occasionally. This has proven very satisfactory, since the employee receives an examination from her doctor. It has reduced the unnecessary cases of absenteeism from this cause. They now spend an hour or so at the Health Centre and after a dose of ephedopyrine go back to work.

In summing up the duties of the industrial nurse, we feel that she is responsible to the management to do everything within her power to share in making the best workman she can out of the material she has at hand. At the Canadian Nurses Association biennial convention the following quotation was made from a report by Mr. Alan Ross, as reported in the *Regina Leader Post*: "In one three-month period 50,000 men were recruited for the forces. Two out of five were rejected". Industry is using those two and trying to make the best of it's handicap. This is where the industrial nurse plays her part in the war effort. She works on the theory that there is no such person as a "lazy person". There must be some underlying cause, health, a square peg in a round hole, or a domestic problem, which may also have a health source. Where the cause relates to health, whether mental or physical, it is the nurse's duty to industry and to the employee to give advice where possible. It is through this all round service that she is able to be of most value to industry and to the community.

ANNOUNCING

a New Subscription Rate

Attention is directed to a change in the subscription rate for *The Canadian Nurse*. The previous rate of two dollars for one year is continued but where a subscriber wishes to renew for a longer period, there is a special rate of three years for five dollars which is available to nurses in Canada, to those serving with the armed forces overseas and to the Canadian nurses who have joined UNRRA. Subscribe for three years and be sure of receiving your *Journal* each of the thirty-six months.

D.D.T.

This is one of the newer alphabetical chemical notations and stands for dichlorodiphenyl-trichloro-ethane, the most effective weapon against body lice ever developed. In its own field it appears to be as marvellous as the sulpha drugs or penicillin. Though known for almost 100 years only now are its properties coming to be appreciated. It is harmless to warm-blooded animals, but fatal to a wide variety of insects. Clothing treated with it remains louseproof after many washings, which is mightily important, for lice are carriers of typhus fever, which has killed more men in former wars than any other one thing.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Teaching the Problems in Drugs and Solutions

GRACE SPICE

One would think that anyone who had had the time I did learning to do Drugs and Solutions problems as a student would have been in and out of all the pitfalls, and I dare say I was. But I assure you that it is not at all the same thing watching someone else fall in as it is falling in yourself. We had an intensive course in the preliminary period and then, just to be sure we were safe to be turned loose on the public, we were given sets of review problems in our last three months. As soon as we had turned in three perfect sets, consecutively, we were exempt from further review. I never did get exempt! Rather a risky business, you say, letting me teach Drugs and Solutions problems? You have some grounds for such a fear. I approached the assignment with misgivings but it is amazing how quickly and thoroughly you can learn a subject if you are responsible for teaching it. After teaching the course four times I still cannot approach a class without careful, last minute preparation and checking of every example to be sure I will not make mistakes with my decimal points. But in the process of learning while teaching I have developed some safety techniques that may be of interest and value to others.

The first time, I made the mistake of passing rather lightly over the difference between liquids and solids. The fact that liquids have to be measured, that it is their *volume* that matters, and that solids have to be weighed, that it is their *weight* that is important, is really easy enough to grasp if it is pointed out sternly and frequently but the first time I left it to be assumed. The practice common in hospitals of measuring some solids by volume for standard solutions does not help the position I took, either. True, for some solids a dram by weight and a dram by volume may be so nearly the same amount that for all practical purposes the two can be considered equal. Also true that it would be impractical to require the weighing of solids anywhere in a hospital except the pharmacy. For commonly used solutions, the directions typed out and hung up on the wards and in the solution room require the use of an amount of the solid that has been checked volume against weight. But true as all these observations are, they indicate the factors that complicate the first simple fact that the student must learn in the course, viz., for each table there are really two tables — one of measures for liquids and one of weights for solids — and the fact that the terms ounce and dram may refer to either a solid or a liquid unit is no help.

The subject of tables brings us to the very brink of the next pitfall. I fell in head over heels the first time. My reasoning went somewhat like this: "Well, they must learn the tables and that right early, so I will give them the whole set, all at once and the equivalents between the two sets for good measure". Oh, that was a sad day! Some of the students in that group never did learn their tables before the course was over. They became so thoroughly confused between grams and grains and the number of grains that are equivalent to a gram that it taught me a lesson. Now I present the two tables early in the course, with special emphasis on their distinctness and we have correlated practice in the laboratory in weighing solids and measuring liquids in the units of both tables. A problem stated in the apothecaries system must be worked in that system and one stated in the metric system must be worked in that system. After two months or so of insisting on this distinctiveness, I introduce the equivalents and problems requiring their use. Laboratory practice is helpful to illustrate the fact that these equivalents are only approximate and the approximation between a pint and 500 c.c. is less exact than that between a dram and 4 c.c. Every time I guide a new group of students through the intricacies of the two tables and their equivalents, I yearn for the day when there will only be one table. A recent decision of the Council on Pharmacy and Chemistry of the American Medical Association to adopt the metric system exclusively in all future publications is pointing the way along a road which looks brighter for the future. Is there any quarter where nurses could bring pressure to bear to establish the use of only the metric system in hospitals in Canada?

From "Nurse Please!", courtesy of J. B. Lippincott Co.

The next pitfall was not really evident to me until I was pretty well through the course the first time. This difficulty arose because of lack of prepared material. I simply did not have enough examples of each type of problem, examples that worked out smoothly without too many bits left over, examples that had some connection with nursing practice, that were more than mathematical practice. So I made some more up and I modified ones I had so that now I have a fair collection with an x marking the best ones!

One other technique that is probably second nature to instructors who are more experienced than I was at first, but which I learned through trial and error, may be stated thus: outline carefully at the outset, what you will accept and what you will not accept in the way of solution and answers. If you are going to insist, as I do, that the statement of the answer must completely satisfy the statement of the problem, with everything repeated in it, then warn the students of these requirements from the beginning of the course.

The course as we teach it in Manitoba comes in the preliminary term and we have recently modified our qualifying examinations so that 30 per cent of the marks on the Nursing Practice paper are allotted to Drugs and Solutions Problems. The following is a general outline of the course:

(1) A pre-test in simple mathematics including: converting fractions to mixed numbers, converting mixed numbers to improper fractions, finding the lowest common multiple and the highest common factor, arranging fractions in the order of ascending value, converting fractions and mixed numbers to decimals, converting decimals to fractions, solving simple equations involving one unknown, review of roman numerals from one to one hundred. Usually, the mathematics involved in converting a ratio into a percentage and a percentage into a ratio requires teaching rather than just review.

(2) An introduction to the science of Pharmacology and the nature of drugs. An outline of the course in Drugs and Solutions. A discussion on the nature of solutions — this usually ties in very nicely with the introduction to Anatomy and Physiology where we discuss protoplasm, the nature of life processes, and the transfer of material in solution and colloidal suspension through the cell membranes.

(3) The problems proper make up the bulk of the course. I have divided the problems into twelve types and make it very clear to the students when we have mastered one type and are ready to go on to another. Practically all of the problems can be worked by the proportion method in which the four terms represent the following:

Term 1. The quantity of stock drug. This stock drug may be a pure drug, in which case it may be either a liquid or a solid, or it may be a stock solution, in which case it is always a liquid.

Term 2. The quantity of the solution desired. This also is always a liquid measure.

Term 3. The strength of the desired solution. This is always the weaker solution.

Term 4. The strength of the pure drug or the stronger solution.

The first and second terms must always be expressed in the same or corresponding denominations, thus: If the first term is in cubic centimetres, the second will be in cubic centimetres or millilitres.

First Term	*Second Term*
grams	cubic centimetres or millilitres
minims	minims
grains	minims
drams (fluid or dry)	drams (fluid)
ounces (fluid or dry)	ounces (fluid)
pints	pints

If the third term is in ratio, then the fourth term must be in ratio; if the third term is in per cent then the fourth term must be in per cent. The strength of a pure drug is 100 per cent and in ratio is 1-1.

Type 1. In this type the first term is the unknown quantity.

Example: How much pure liquid lysol is needed to make 10 ounces of a 2.5% solution of lysol? (apothecaries system).

Example: How would you prepare 500 c.c. of a 1% solution from pure liquid lysol? (metric system, and the problem stated less directly but requiring the same type of working).

Example: How would you prepare 500 c.c. of a 1-100 solution from a 1-4 solution of a drug? (using ratio instead of per cent and a strong stock solution instead of a pure drug).

Example: How would you prepare 100 c.c. of a 1-25 solution from Magnesium Sulphate crystals? (using a solid for the pure drug).

The following rules introduced at the end of the class on Type 1 problems may sound very abitrary but they help the shaky student to skirt the pitfalls and they do not burden the self-assured student unduly. Incidentally, of course, they make the correcting of problems infinitely easier for the teacher:

1. If the problem is stated in the apothecaries system it must be worked in that system.

2. If the problem is stated in the metric system, it is to be worked in that system.

3. If the strengths of both quantities is expressed in per cent, the problem is to be worked in per cent.

4. If the strengths of both quantities

are expressed in ratio the problem is to be worked in ratio.

5. If, however, the strength of one is in per cent and the other in ratio, then one must be changed to the other (it does not matter which) before the problem is worked.

6. The wording of the answer must satisfy the wording of the problem. If the problem asks you how to prepare a solution, then your answer must give instructions as to how much drug to use and how much water to use to make the required amount of solution. A statement which applies whether you are using a solid drug or a stock solution or a liquid pure drug runs as follows: In answer to the third example above—to prepare 500 c.c. of a 1-100 solution from a 1-4 solution, use 20 c.c. of the 1-4 solution and add enough water to make 500 c.c. of solution.

The answer for the first example, however, need not go into detail as to the preparation of the solution and could read simply: to make 10 ounces of a 2.5% solution of lysol, you will need two drams of the pure drug.

All these modifications and instructions are dealt with under Type 1 in which the first term is the unknown. Also at this point it helps some of the students if they are taught how to prove their answers by introducing the formerly unknown quantity into the problem and making some other quantity the unknown. It is also good practice in understanding the various terms if they put into words the new problem that they have thus created.

Type 2. In this type the second term is the unknown.

Example: How much of a 20% solution can be prepared from 5 grams of a pure solid drug? (Here again all the modifications worked in under the examples in Type 1 will be dealt with in practice problems to be worked out-of-class.)

Type 3. In this type the third term is the unknown.

Example: What is the strength in ratio of one litre of solution containing 25 grams of Bicarbonate of Soda? (This is modified to ask for the strength in per cent).

Type 4. This is a rare type, purely hypothetical you might say. Does it ever happen that the fourth term is the unknown, that you do not know the strength of the substance from which you made a solution?

Example: It requires 10 c.c. of a drug to prepare 400 c.c. of a 2.5% solution. What is the strength of the drug? (I teach that type anyway just to round out the picture.)

Type 5. This type deals with the use of drugs in the form of tablets, and requires two subdivisions.

Example: How many gr. ½ tablets of a drug are needed to make five drams of a ½% solution of the drug? (This could rightly be called a modificaion of Type 1 in which the first term is the unknown, but I prefer to hold it over for a while and avoid making too many modifications of Type 1 all at the first of the course).

Example: Find the strength in ratio of one dram of solution containing nine gr. 1/3 tablets of a drug. (This again could be called a modification of Type 3).

Type 6. This is the type that I call the catch problem.

Example: A solution was made by adding two drams of pure alcohol (a liquid drug) to one ounce of water. Find the strength of the solution in per cent.

This obviously belong to Type 3 but the catch is in filling in the quantity of solution for term 2 in your proportion. When you add two drams of drug to one ounce or eight drams of water, you have ten drams of solution for your second term.

Type 7. With this type we leave the plan that we have followed so far and find a new method. This type solves the problem of how to administer an ordered number of grains of a drug from a stock solution containing so many grains to the dram.

Example: How would you administer ten grains of Sodium Salicylate from a solution containing fifteen grains to the dram?

To solve this we use a proportion in which the figures for the first two terms are derived from the label, the third term is the dosage ordered by the doctor, and the fourth term is the unknown. Thus 15 gr. 1 dram: 10 gr: x drams. Just one warning, the first and third terms must be in the same unit, such as, grains, and the second and fourth terms must be in the same unit, such as, drams.

After a little discussion on the advantages of keeping some drugs in stock solutions rather than in tablet or powder form, just to reassure the student that there is some sense in learning to do this type of problem, I introduce a modification of this type. Example: How would you give grains ½ of a drug from a 2% solution? Magendie's Solution can be worked in under this heading if it is thought necessary to teach it.

Type 8. This type deals with the administration of Insulin and the method is the same as in Type 7. The first and second terms are obtained from the label on the bottle, the third is the number of units ordered by the doctor, and the fourth term is the unknown amount of fluid to administer to give the required number of units. I know that most students can work out insulin dosages without pencil and paper but it is always wise to have a system for the few who cannot.

Type 9. This type of problem is preceded by a laboratory class in the use of the hypodermic syringe and practice in measuring quantities of fluid in it. This is a good place to start introducing the equivalents between the apothecaries and the metric tables. Seeing the liquid equivalents on the syringe helps to make the relationship between the two systems easier to grasp. Type 9 can be stated as the problem involved in administering a different fractional part of a grain than that contained in the tablet on hand.

Example: How would you administer gr. 1/6 of a drug from a tablet containing gr. ¼, of the drug.

I do not think that there is more than one way to work this problem so there is no need of a detailed description but one thing I do require. The answer to the problem must state the steps taken to secure the result. For example, the answer to the above problem should read: to administer gr. 1/6 of a drug from a tablet containing gr. 1/4, dissolve one gr. 1/4 tablet in minims XXIV of water and save minims XVI of the solution to administer. This type has to be modified to include problems in which more than one tablet is required and in which whole tablets and fractional parts of tablets are required.

Type 10. This type deals with computing children's dosages and has three sub-headings dealing with the three most commonly used rules:

1. Figuring from the adult dose, to find the dose for a child over one year of age. The fraction here is made up of the age of the child in years for the numerator and the age plus 12 for the denominator.

2. Figuring from the adult dose to find the dose for a child under one year of age. The fraction here is made up from the age of the child in months as

the numerator and 150 as the denominator. (The average age for puberty is 12.5 years or 150 months).

3. Figuring on a basis of a comparison of weights rather than ages. The fraction here is made by using the weight of the child in pounds as numerator and 150 as denominator. (The average weight for an adult on which standard dosages are computed is 150 lbs.)

Type 11. It is well if you feel you need some excuse for burdening the students with this type to work it in when you have them impressed with the importance of children's dosages. It deals with a fairly accurate means of obtaining a fractional part of a minim if such a thing should ever be necessary. You cannot measure a half a minim accurately in a hypodermic syringe so what would you do if you were ordered to give a half a minim of a very potent drug to a very small infant? Dilute one minim of the drug in a known quantity of water so that you can take half of the resulting solution with a degree of accuracy and administer it. You have to watch here, of course, to be sure that your total solution, drug plus water, adds up to a number of minims that is evenly divisible by the denominator of your fraction. Also if your drug is to be administered by hypodermic, the final amount of fluid must be kept small enough to be acceptable.

Type 12. This group really gives room for reviewing many of the other types because it includes problems in which both the metric and the apothecary units are used and a knowledge of the equivalents is necessary. Learning the acceptable equivalents is facilitated by considerable laboratory practice in weighing and measuring in both systems. Throughout the course the student works a set of 10 problems each week outside of class time and these are corrected and returned for guidance.

The laboratory equipment with which each student is supplied includes the following: Medicine glass, drinking glass, drinking cup, hypodermic syringe, 25 c.c. cylinder, medicine bottle, tablespoon, teaspoon, minim glass, medicine dropper. Besides the laboratory practice that has been mentioned previously, students are given experience along the following lines: practice in pouring from a medicine bottle; evidence of the relative inaccuracy of a medicine dropper to measure minims; practice in judging how much a drinking glass and cup will hold as an aid in recording fluid intake; practice in preparing hypodermic tablets for injection and measuring fractional parts of a minim.

All these learning aids are made available to the students under guidance and I do feel that they are of enough value to warrant the time consumed. But I still feel that the surest way to victory over Drugs and Solutions Problems is to have to teach someone else how to do them. I am sure that is why my friend in training got exempt so early from our review assignments. She worked so hard trying to teach me how to do them that she certainly became expert herself.

Preview

No less an authority than Dr. S. R. Laycock has prepared a guide for happy, useful living in an article entitled "The Mental Health of the Nurse". We are accustomed to think of the needs of our patients, to consider their psychological as well as their physical needs. It is an interesting study to turn the searchlight on ourselves and see what an eminent psychologist considers essential for us.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

The School Health Committee

FLORENCE INNES

Good health, both physical and mental, is recognized to-day to be one of the primary objectives of education. It is an acknowledged fact and at the present time a much publicized fact that the health aims of our educational systems and health departments are not being realized to the extent that should be possible in a country such as Canada. We are not producing enough first-class citizens.

Although there may be many factors beyond our control which have influenced the health status of our people, it nevertheless behooves us to examine carefully the functioning of our various health programs in an attempt to discover and correct weaknesses that may exist.

The school health program is a co-operative undertaking, the success of which depends on the degree of understanding that exists among those responsible for carrying it out, namely the medical, nursing, teaching and administrative staffs. It naturally follows that opportunity must be provided, particularly in a large organization for representatives of these groups to meet and discuss their various problems if they are to work effectively toward a common goal. This article attempts to describe the formation and functioning of School Health Committees in the Vancouver School System.

In this city the school medical, dental and nursing services are administered by the School Hygiene Division of the Metropolitan Health Committee which carries on a generalized public health service in Vancouver and surrounding municipalities. Policies with regard to health service in the schools were, until the formation of the Health Committee, developd through consultation of the chief school medical officer, directors of nursing and dental service with the superintendent of schools, following consultation with medical and nursing staffs.

In May 1943, a committee was formed which is known as the Vancouver City Schools Health Committee having as its objective the study of ways and means to improve health education and health services within the Vancouver school system. The personnel of the Committee includes members of all groups concerned. Representing school administration and teachers are the superintendent of schools and his assistants, the supervisors of home economics, health and physical education, primary work and special classes, a sceondary school principal, an elementary school principal, a teacher of health and a

janitor-engineer. Representing the Health Department are the senior medical health officer, the chief school medical officer, the director of public health nursing, the director of dental services, the medical director of a health unit and the nursing supervisor of a health unit.

The objectives, outlined at the first meeting, are as follows:

1. To advise as to how the school health service can become increasingly educational in character.

2. To aid in recognizing the educational possibilities of the health service and in utilizing the opportunities offered by it in health instruction.

3. To co-ordinate the services rendered by teachers, school doctors, nurses and dentists.

4. To advise concerning procedures affecting health in the school program.

Realizing at the outset that the central committee could not work alone, it was recommended that individual health committees be formed in each school to act as a liaison between the central committee and the teaching staff, for the purpose of disseminating information and suggestions. An additional objective was added: to develop in all members of the school staff a consciousness that the first aim of the school is "to develop young Canadians sound in mind and body" and that this can only be attained through the understanding and co-operation of every member of the staff.

The personnel of the individual school committee consists of the school principal, the public health nurse, a teacher of health and physical education and one other teacher. Other staff members to be utilized on the committee as occasion demands are: the school janitor, a home economics teacher, a representative from the students council, a students' counsellor, other teachers and the school doctor.

While most of the secondary schools already had health committees functioning, the idea was new to the elementary schools, so the following suggestions for study were sent out as a guide for discussion: absenteeism; nutrition, including school lunches; relation of school sports program to the health of the individual pupil; personal hygiene of the pupil; first aid; the improvement of physical examination from an administrative standpoint; teacher-parent-nurse conference; health education program (actual teaching of health); educational preparation of pupils for special medical procedures such as toxoid clinics, tuberculin testing, etc.; pre-school meetings of mothers, teachers and nurses; visits of pre-school children to the school; other topics of special interest to individual schools.

It was also planned to keep individual school committees informed of the activities of the central committee by means of bulletins. Suggestions or problems are presented by the school committees to the central committee by means of a letter or by requesting representation at the next meeting. The accomplishments of the central committee to date are as follows:

1. Formation and guidance of individual school health committees.

2. Preparation of a leaflet for parents giving general instructions on the care of the common cold. This is sent home with the children suffering from colds and teachers are provided with the leaflets to give to the children sent home for this reason when the nurse is not at the school.

3. The preparation of an attractive pamphlet to be distributed to parents of children starting school, outlining the responsibility of the parent toward the school child.

4. The preparation of a form for reporting absentees.

5. Clarification of the policy regarding remedial exercises.

6. Clarification of regulations regard-

ing re-admission of children to school following illness.

7. Appointment of a committee to study sex education in schools.

The central committee has been in operation only a little over a year and the members are enthusiastic about its value in developing and improving the health service and health education program in our schools.

The Treatment of Talipes Equinovarus

EDGEWORTH MURRAY

The change that has taken place in the treatment of talipes equinovarus is most gratifying. Anaesthetics and plaster casts, pain and pressure sores, are out of vogue, and in their place are splints consisting of foot-pieces, a cross-bar, screws and nuts. Each foot is strapped to two metal splints or foot-pieces and these are then bolted to a cross-bar. In this way a point of fixation is obtained for each foot. These splints are known as Denis Browne splints. The foot-pieces are L-shaped and made of duralu-minium one-sixteenth of an inch thick. The sole plate is flat, approximately the length of the child's foot and a little wider. The side-piece is continuous and set at an angle of about one hundred degrees with the sole plate. The side-piece is curved outwards to clear the external malleolus; immediately above this it is curved in the opposite direction so that the convex surface approximates to the leg, a layer of felt intervening. The free edge is therefore well away from the skin and in no danger of press-ing into it. The infants are happy and comfortable and need not stay in hospital long, as this treatment can be carried on at home if the parents are intelligent and follow the surgeon's instructions, and make regular visits with the child to his office. It has been found inad-visable to wash the feet with soap or water, or in fact anything else, during the entire course of treatment, not even when the feet are released from the splints and the adhesive is to be immedia-tely readjusted, as there is danger of breaking the delicate skin surface, and in-troducing infection as a complication. The nurse or mother has to school her-self to ignore this urge, and the result-ing odour as well. These infants are not "tucked into bed" — they are left on top and have light blankets which are free on all sides as covering. This enables the child to kick and move his legs freely with the splints. It is a treat to see how happy they are. We use blanket clips with elastic and tape as a control; these fasten to the pillow, grasping the upper corners of the blank-et.

Preview

Last April we published a delightful sketch descriptive of the advanced course in practical obstetrics planned for the district nurses of Alberta. Mrs. Barbara Eben, who served as instructor in ob-stetrics to the group during their course, has outlined the details for us in her story of "Training Storks for Alberta".

Interesting People

Honouring **Matilda Elizabeth Fitzgerald** on the occasion of her seventeenth anniversary as executive secretary of the Registered Nurses Association of Ontario, the past presidents and retiring board members recently presented her with a beautiful hand-wrought brooch, a dainty pattern worked in petit point framed in gold. When Miss Fitzgerald first assumed her duties, her office was a room in her own home and her desk a card table. From five hundred members in 1927, the R.N.A.O. has grown to be the largest provincial association in Canada with seven thousand members and a staff of four employees in the provincial office. The *Journal* wishes Miss Fitzgerald many more happy years of service.

The medical staff and graduate nurses of the Prévost Sanatorium held a reception recently in honour of **Charlotte Tassé**, for twenty-five years the director of nursing in this hospital. Miss Tassé has not only carried the heavy responsibilities of this nursing school but also found time and energy nearly twenty years ago to establish *La Garde-Malade Canadienne-Francaise* of which journal she is still the editor.

MATILDA FITZGERALD

Lillian Gertrude MacKenzie, B.A., a graduate of the Royal Victoria Hospital, Montreal, and the School for Graduate Nurses, McGill University, has been appointed acting director of the Nursing Division of the City Health Department, Winnipeg. Miss MacKenzie was with the Victorian Order of Nurses in Montreal and Winnipeg before joining the staff of the Winnipeg Health Department.

Edith Fenton, a graduate of the Sick Children's Hospital, Toronto, and the University of Toronto public health nursing course, is engaged as health instructor to both staff and patients at the Toronto Hospital (tuberculosis), Weston, Ont. For several years Miss Fenton was attached to the University Health Clinic in Halifax and latterly was chief nursing officer with the St. John Ambulance Association at the headquarters in Ottawa.

Mrs. R. L. Smith has accepted the position of superintendent of the Queen Alexandria Hospital at Ingersoll. Mrs. Smith, who graduated from Victoria Hospital, London, will assume her new duties on December 1.

Alice G. Nicolle, a native of Jersey, Channel Islands, and a graduate of the Presbyterian Hospital School of Nursing, Philadelphia, Pa., and the School for Graduate Nurses, McGill University, has been appointed educational supervisor, Division of Nursing, Ontario Department of Health. After a few years of institu-

Chidnoff Studio, N.Y.C.

ALICE NICOLLE

N. Featherstone Cowley

MARGARET DULMAGE

tional work, Miss Nicolle turned to public health nursing and worked for five years with the Victorian Order of Nurses in Montreal and Toronto followed by experience as supervisor and health adviser in the secondary schools in St. Catharines, Ont. and rural director in the Northern Rhode Island health services.

Co-ordination of the nursing services of the Ontario Division of the Red Cross has come about with the appointment of **Margaret Dulmage** and **M. I. Foy** as supervisor and assistant supervisor respectively of the home nursing and emergency reserve, Ontario Division of the Red Cross. Supporting Miss Dulmage and Miss Foy in the province are four district leaders: Mrs. A. C. McKenzie, Beaverton; Mrs. Hugh Campbell, Orillia; Beatrice Moreland, Kingston; and Mabel Hardie, London. The development of home nursing, first aid and emergency nursing reserve, and finding an enlarged place for the Division's nursing activities in the peace-time program will be the aim of this department of the Red Cross. The latter has already been given leadership by the Provincial Department of Health.

Miss Dulmage was for many years instructress of the preliminary students in the school of nursing, Toronto General Hospital. She has won for herself a unique place in the nursing world. Miss Foy was a former organizer for the Mobile Division, of the Blood Donor Service (Ontario) and for many years was engaged in social service and public health nursing. The Ontario Division is fortunate in securing the services of

M. I. FOY

such outstanding women in the nursing profession to direct the activities of this important Red Cross project.

Anne Sayer, a graduate of the Hamilton General Hospital and the University of Toronto public health nursing course, has accepted a position with the Ontario Society for Crippled Children.

Annual Registration

An analysis of the state registration requirements affecting nurses in military service has been published in the September 1944 *American Journal of Nursing*. The majority of the states do not require the payment of annual re-registration dues so long as the nurses are attached to the service. Varying lengths of time are provided, following discharge, when the nurse may be re-instated upon payment of the current fees. In several states, special legislation has been enacted to permit this privilege.

Early in Canada's participation in the war, the Executive Committee of the C.N.A. passed a resolution urging the provincial associations to consider the problem of annual re-registration for nurses serving overseas. The following is an outline of the regulations which our provincial associations have made in this regard:

Alberta: Members who have joined the armed forces but who remain in Canada are considered in the same category as civilian nurses and must pay the annual fee of three dollars. Members of the Association on war services overseas are automatically granted an exemption and are not required to pay any annual fee until their return to Canada when the current year's fee becomes due. Members who have joined the armed forces and who are honourably discharged, and are in good standing with the Association, may be exempted so long as they are not nursing within the province by notifying the Registrar. Nurses whose fees have lapsed must pay for the current year plus back dues up to a maximum of fifteen dollars.

British Columbia: The fees of all nurses in good standing who have proceeded overseas on active service are waived until six months after their return to Canada. The Association pays one dollar for each of these members annually in order to retain their registration intact. This arrangement applies to all branches of the service. Nurses must pay their annual dues of five dollars if in B. C., three dollars if elsewhere in Canada, to remain in good standing. Nurses who have allowed their fees to lapse must pay the current fee plus back fees up to a maximum of ten dollars.

Manitoba: Nurses in military service are required to maintain active membership. Those who have permitted their registration to lapse must be re-instated by payment of a re-instatement fee of one dollar, plus the current year's membership fee of three dollars.

New Brunswick: Members serving with the armed forces within the province, pay the regular renewal fees of three dollars twenty-five cents. Those on duty elsewhere pay a non-resident fee of one dollar per year.

Nova Scotia: No special provision has been made for nurses on military service. Regardless of where their duties call them, they are expected to pay their annual fees of three dollars. The regular rules for fees in arrears hold.

Ontario: Membership in the R.N. A.O., being distinct from registration, the regulations are somewhat different from those in other provinces. The annual fee for membership in the provincial association is two dollars. If a nurse has allowed her membership to lapse, she may be re-instated on payment of the fee for the current year, plus two dollars for arrears.

The registration fee is one dollar and is due each year. No change has been made regarding the payment of fees in connection with the nurses in the armed services.

Prince Edward Island: The annual renewal fee is two dollars. Provision is made for inactive nurses who are required to pay one dollar per year to retain membership in the Association.

Quebec: The by-laws calls for an annual renewal fee of two dollars and fifty cents and make provision for those who do not renew. No special provision is made to exempt nurses who are serving overseas who, it was unanimously decided, should maintain active membership.

Saskatchewan: Up until 1943, nurses going overseas were advised to place their names on the inactive list which entitles them to re-instatement upon payment of the current fee of three dollars. Since 1943, in order that they might maintain their affiliation with national and international nursing organizations, nurses enlisting with the armed forces have been advised to keep up their provincial registration, although the inactive privilege is still open to them.

A Nurse in the South-west Pacific

(*Editor's Note*: The following excerpts from letters received from Lieut. Adele Billinkoff, a Canadian nurse with the U. S. Army Nurse Corps, were sent to us by her sister, Ada Billinkoff of Winnipeg. They indicate that there is a lighter side to the army nurse's work.)

We have just completed the most delightful southern cruise to reach this station. It is situated in a beautiful spot and has a splendid hospital with a real south seas atmosphere, such as little brown men to wave you a hilarious welcome. And there is no mistake about this being the tropics. It is hot! We wear culottes in the daytime and slacks at nigh.t For dress up occasions the girls wear white shirts instead of coloured ones. The ocean is right outside our windows and our quarters are thatched huts, screened in and complete with a floor. For beds we are back to our little canvas cots. We go to sleep with the surf pounding in our ears. We have been working hard getting our huts liveable. We built three dressing tables and made skirts for them out of an old sheet, trimmed with material from a pair of my pyjamas. We also have a table and chairs but don't ask me how we got them. Our laundry is done by little natives who don't look any older than ten years. Most of them wear a sarong and a "Mother Hubbard". The latter are blouses gathered at the neck and sleeves.

While swimming in the ocean yesterday we lost an inflated rubber boat. A native family found it and they all streamed over returning it. The wee little fellows are adorable and look just like pickaninnies without their coarse features. We gave the family all the gum we had and most of our cigarettes. They just revere a white woman — touch

you gently and smile like angels. I laughed at one of our boys trying to speak pidgin English to the natives only to have an older native boy turn to me and say "What is your name, Miss?" and repeated it after me without a hitch.

One day we did a little trading with the natives but didn't get much. We procured a few strings of beads which I've had autoclaved. The kids just swarmed around and practically stripped me of all my hairpins and safety pins. I could not imagine what they wanted safety pins for until I saw a rather curious sight. A little tot was sitting cross-legged beside her grandfather. She was a beautiful little thing with perfect features and big brown eyes. There she sat, perfectly motionless, with a long earring dangling. As we snapped her she stood up and the earring was a large safety pin!

Coming home over miles of rough road made us very thirsty. We felt so contaminated after our visit with the natives that we didn't dare touch our cups, but, lo and behold! when we went to wash we found that someone had mixed all our water with grapefruit juice. We calmly washed our hands in gasoline and rinsed them off with juice. Seems there is nothing too good for us!

There is a native section in the hospital too. When we admit a native the whole family moves in. Just now, we have a Filipino woman with osteomyelitis who brought along her two little boys. The youngsters are darlings — gum will buy their undying devotion. The mother is a very intelligent person. At the commencement of hostilities her home was destroyed by the Japanese and her husband and older son taken prisoners. She was rescued and spirited away with her two little sons. She told me how good the natives were to her and how they fed her bananas and sweet potatoes, the staples of the natives. For eighteen months that is all she ate so no wonder she is sick! Incidentally, she is being cared for by the daughter of the native who rescued her.

We've had a bad time the last few nights with one of our native patients. We thought he had pneumonia but a spinal puncture showed meningitis. It's quite a problem nursing the boy. *We* know what to do but to make his fellow natives understand is another thing altogether. Isolation, as we know it, is impossible as you can't keep the rest of the natives away. They are so devoted to each other they all want to help.

All is not sad and sombre though. Not long ago we went on a very interesting trip to a native village. The first place we visited the natives were having a celebration. They seemed extremely friendly and sang their native songs for us. As we were listening to their singing a familiar tune crept in and before we knew it they were singing, "Don't sit under the apple tree"! Then came, "You are my sunshine" and others. I've never heard anything so funny as their rendition.

LIEUT. ADELE BILLINKOFF, R.N.
U. S. Army Nurse Corps

Changing your Address?

Subscribers changing addresses should notify *The Canadian Nurse* one month before the change is to take effect. Both old and new addresses must be given. The *Journal* cannot replace copies which are lost because of incorrect addresses.

Tuberculosis Congress

For the first time in the history of Mexico, a congress for the study of tuberculosis has been held. The Comite Nacional de Lucha Contra la Tuberculosis plans to establish a national institute for tuberculosis.

—*The N.T.A. Bulletin.*

Notes from National Office

Contributed by G. M. HALL

General Secretary, The Canadian Nurses Association.

Taking over new duties and responsibilities in National Office on the eve of an executive meeting is an interesting even if somewhat confusing experience. However, with the co-operation of the entire personnel your general secretary has managed to assemble some interesting notes. From hospitals, sanatoria, public health organizations come sad stories daily of the transiency of nursing personnel, and National Office is no exception. It is with regret that we must inform our readers that we are about to lose Miss Florence Walker, assistant secretary, who has given such faithful and conscientious service during the short time she has been associated with National Office. While we regret Miss Walker's decision to leave the national field, we are pleased to learn that she will continue to work in the association, having been selected by the R.N.A.O. to assist the secretary-treasurer of that very active organization. Our good wishes accompany Miss Walker in her new field of endeavour.

Nurses everywhere are continuously being challenged during these days of rapid change and development. We refer particularly to the challenge which we must be prepared to meet if we are to assist our returned men and women to re-establish themselves in civilian life. There is no doubt that the adjustment period for this great army of workers and their families will be most difficult.

Public health nurses are familiar with the problems of the tuberculosis patient who, after long periods of sanatorium care, must learn to adjust to the home and community. Along with this, the public health nurse is required to help the family to accept the patient after a long period of absence. Now we must be prepared to expand that service on a very broad scale, to help develop an understanding and tolerance toward those who will resume peacetime occupations. Are we as nurses prepared to accept this challenge? If not, we should seek opportunities to increase our knowledge of mental hygiene and psychiatric nursing. The editor of the *Journal* has kindly informed us that a series of excellent articles relating to this most important aspect of nursing will shortly appear in the pages of the *Journal*.

South Africa Nursing Act

The July number of *The South African Nursing Journal* brings news of the passing of a Nursing Act at a recent session of Parliament, which will come into force at the end of 1944. It will then be compulsory for all practising nurses and midwives to become members of the South African Nursing Association. Tribute should be paid to those nurses and midwives who, through supporting the Association by their mem-

bership, have obtained protective legislation which gives self-government to the nurses and midwives of South Africa.

A nursing council is being established consisting of tweny-four members, including the chief health officer or any other officer of the Department of Public Health; the commissioner of mental hygiene or a superintendent of a state mental hospital; two persons not registered under the Nursing or Medical Act, to be appointed by the Minister of Health; two medical practitioners appointed by the Medical Council; one person appointed by the executive committee of each province, ten nurses elected by the nurses registered under the Act; three midwives elected under the Act; and a person who is registered under the Act both as a nurse and as a midwife, elected by student nurses and student midwives.

Among the powers of the Council, the following are of interest: (a) the keeping of a register; (b) to prescribe qualifications and conditions for admission or re-admission to the registers, including the nature and period of the training required, the examinations to be passed and the recognition of qualifications obtained outside the Union, and to prescribe the conditions for removal of names from the registers; (c) to prescribe curricula, appoint examiners, conduct examinations and grant certificates; (d) to approve of schools of nursing or other places where nurses and mid-wives are trained; (e) to prescribe the fees payable to the Council in respect of admission or re-admission to the registers, of examinations and of the issue of certificates; (f) to deal with disciplinary matters.

An interesting feature of the Act concerns regulations. When a regulation is passed by the Council which, in the opinion of the Minister, affects the medical profession, and when a regulation is passed or recommended by the South African Medical Council constituted under the Medical Act, which in the opinion of the Minister affects the nursing or midwifery profession, the Minister shall not approve of such regulation without having consulted the South African Medical Council or the Council, as the case may be.

The nursing association has as its objectives the provision of efficient and adequate nursing and midwifery service for the Union, to raise the status and promote the interests of the nursing and midwifery professions, to consider and deal with any matter affecting nurses, midwives, student nurses or student midwives. The control of the association is to be vested in the Board, consisting of ten members representing registered nurses and registered midwives.

I. C. N. Conference

A meeting of available members of the Board of Directors, International Council of Nurses, and committee chairmen was held in New York, October 6 and 7. In addition to Canada and the United States, representatives were present from Brazil, China, India and New Zealand. Reports were presented from all countries represented. Discussion centred largely on resumption of I. C. N. activities as soon as possible. The president, Miss E. Taylor reported that, directly or indirectly, contact had been established with twenty-one national members and that all mentioned the need for renewing contacts and becoming active. The value of the I.C.N. in foreign countries was emphasized by representatives, two of whom stated that when other influences seemed to fail results were obtained by quoting the I.C.N. Recommendations were as follows:

1. The nurses going with UNRRA should be instructed to contact, when

possible, the leading nurses in the countries to which they go and to bring them up to date with the I.C.N.; also to work with national associations where they still exist.

2. That, when possible, Miss Schwarzenberg should visit South America. Chile and Colombia have formed national associations and are asking for membership. Other Central and South American countries are asking for advice on forming an association.

3. That when possible the nursing laws of all countries be compiled for reference.

4. That a post-war planning committee be set up.

A proposed revision of the By-laws was presented by Mrs. Alma Scott, executive secretary of the A.N.A., accompanied by a suggested plan for a constitution and by-laws for national organizations.

Florence Nightingale International Foundation:

There was very free discussion and a resolution in regard to the broadening of the scope of the Foundation. More details of this will be given in a later report.

Executive Meeting

A meeting of the executive committee of the Canadian Nurses Association was held in Montreal, October 27-28. Those present included: president, Miss F. Munroe; past president, Miss M. Lindeburgh; second vice-president, Miss E. Cryderman; honourary treasurer, Miss M. Jenkins; convener of committee on nursing education, Miss E. K. Russell; chairmen of sections; Miss M. Batson, Hospital and School of Nursing; Miss H. McArthur, Publice Health; Miss P. Brownell, General Nursing; and the following councillors: Miss G. Fairley (B.C.); Miss M. Diederichs (Sask.); Miss L. Pettigrew (Man.); Miss J. Masten and Miss C. Livingston (Ont.); Misses E. Flanagan, W. MacLean and A. Robert (Que.); Miss M. Myers (N.B.); Miss M. Kerr, editor and business manager, *The Canadian Nurse*; Miss G. Hall, general secretary; Miss F. H. Walker and Miss E. MacLennan, assistant secretaries. Upon invitation: Miss M. Fitzgerald, provincial secretary (Ont.); Miss F. Upton, secretary-treasurer (Que.); Miss E. Beith; Miss J. Trudel, French-speaking associate adviser; Miss D. MacRae, Matron-in-Chief, R.C.A.M.C.; Miss E. Johns; Miss N. Fidler.

General Nursing Section

The convener reported the need for greater unity, for more active participation in the section and association activities by private and general duty nurses. She mentioned the manifold problems of the nurses' registries and placement bureaux and raised the ever-present question of nurses bearing the financial burden of supplying this community service. The provincial general nursing sections will have an opportunity to study the problems and needs when the convener has had time to prepare the necessary questionnaire.

Public Health Section

Contact has been established with the chairman of each provincial section. Copies of recommendations passed at the biennial meeting regarding salaries, hours of duty and pensions have been distributed for information and guidance.

Hospital and School of Nursing Section

An effort has been made to stimulate an interest in the Hospital and School of Nursing Page in the *Journal*. Some excellent material will be appearing shortly as a result of this campaign.

Miss Gwladwen Jones, instructor of nurses, Toronto Western Hospital, has been appointed convener of the Committee on Instruction for the C.N.A. Some research work on the mask as a protective measure will be undertaken. The question is asked "How long do we consider a mask clean?" We await with interest the result of this timely study.

Reports of Special Committees

Interesting reports were received at this meeting and important decisions were made. A general account of these will be given in the *Journal*. More detailed reports and recommendations will appear later.

Publicity and Student Nurse Recruitment

Two new pamphlets on student recruitment have recently been sent to provincial conveners. A continuous program of publicity by films, radio and press was reported. The importance of vocational guidance was stressed and we quote again the advice of our publicity representative: "The various media which we have discussed form an excellent background of mechanics, but it is through the individual counselling that our greatest returns should accrue".

An excellent vocational monograph on Nursing was prepared for and upon request of the Vocational Guidance Centre in Toronto. Recruitment of college-level women for nursing requires a more effective means of presenting nursing to them, and in turn nursing must set its house in order if we are to assure students who enter nursing that they will be given a program and environment that will contribute to their personal as well as to their professional development. This was left to us as our challenge.

Government Grant Committee

The Executive Committee, C.N.A., endorsed the recommendation of the Government Grant Committee, that the Canadian Nurses Association request a grant from the federal government for 1945-46.

Committee on Placement Bureaux

In an endeavour to facilitate the immediate study and development of placement bureaux the convener has been granted permission to organize a core committee, the members of which are familiar with placement service problems. Provincial representatives are to be kept informed and are also expected to contribute information and suggestions to the core committee. At this point of development it was agreed that central organization was not yet justified but that an effort should be made to coordinate the work, so that some degree of uniformity would exist. This matter is now under consideration.

Extracts from provincial reports will follow in the next issue of the *Journal*.

A special message of greetings and cordial wishes for 1945 is extended to readers of the *Journal* from National Office. We share with you the fervent hope that 1945 may bring much longed for victory.

Annual Meeting of the N.B.A.R.N.

The twenty-eighth annual meeting of the New Brunswick Association of Registered Nurses opened in the Fraser Memorial Hall, Fredericton, at 10.30 a.m. on September 20, Rev. Sister Kerr, president, presiding. A very satisfactory number of members were in attendance, which continued through all the sessions. After repeating the Lord's Prayer in unison, Alderman Brewer, representing the City of Fredericton, in the absence through illness of Mayor Ray T. Forbes, extended a very gracious welcome to the members.

Following the appointment of committees, Sister Kerr gave her presidential address, highlights of which were: shortage of nurses; the subsidiary worker; accelerated course for student nurses; placement bureau; the reconstruction period, all of which, Sister Kerr pointed out, will require considerable careful study.

After discussion regarding the increase in the per capita fee from seventy-five cents to one dollar a motion carried that the annual registration fee be increased from three dollars per year to three dollars and twenty-five cents.

Miss Marion Myers gave a report of the 1944 C.N.A. Biennial held in Winnipeg which she attended as a delegate. Miss Myers's resumé covered, very completely, the reports and addresses given at this meeting.

Following the noon recess Sister Kerr introduced our guest speaker for the afternoon, Miss Margaret Kerr, editor and business manager of *The Canadian Nurse*. Miss Kerr gave us a very comprehensive picture of a Placement Bureau, or Placement Service, and outlined her talk as follows: What we understand by Placement Service; how it functions; how such service might be organized in New Brunswick. Miss Kerr then explained the varied functions of Placement Service: 1. As a medium through which employment can be secured by nurses for the type of employment they desire. 2. As a medium for finding suitable nurses for positions that are vacant. 3. To act as counsellor and guide to nurses. 4. The studying of community needs, e.g., new type of service needed. 5. The supervision of the subsidiary worker.

Following Miss Kerr's address, an informal discussion was held regarding the organizing of such a bureau.

Miss Bertha Gregory, convener of the Health Insurance Committee, presented her report, explaining and clarifying many points, which was most interesting and showed a great deal of time and study had been spent on this subject.

Miss Dorothy Parsons presented a report on Post-war Planning as it affects the province, especially regarding employment, improved educational facilities, social and welfare services, increased hospital service and increased number of public health nurses. We were urged to consider the nursing conditions of normal times and those of depression years and to plan accordingly.

In the evening a banquet was held, with Major I. R. Rousse, M.A., M.C., as guest speaker. Major Rousse's subject was the one uppermost in our minds at the present time and which had already been discussed—"Reconstruction and Rehabilitation". We were all glad to listen to a very interesting and informative talk. Major Rousse emphasized that rehabilitation was not a local problem or individual need, but a world-wide plan in which every person and every organization must play a part, and that we must endeavour to understand the individual, what he has been through, and his or her particular need and the background leading up to that particular need. The speaker stated that Canada's plan for rehabilitation was second to none and was being continually worked on and brought up to present-

day conditions. Taking concrete examples, he told us in round figures just what would be done to help these people find their place once again in the world of peace.

On the morning of the second day, Miss M. Myers, convener, Hospital and School of Nursing Section, presented her report, emphasizing the following points: 1. Periodic shortage of nurses, especially among the general duty group. 2. Most schools showed an increase of applicants over last year, due perhaps to our publicity campaign. Miss Myers also stated that shortage of nurses would give rise to the following situations: poorer quality of student nurses; overwork of student nurses; increase in the number of subsidiary nurses who will undoubtedly produce a post-war problem for the private duty group.

Considering these problems, the following suggestions were presented:

1. We ask the co-operation of attending medical staff in relation to: (a) admission of patients into hospitals; (b) length of patient's stay in hospital. 2. More sharing of this responsibility by the Hospital Association with the Nurses Association. 3. More economy of private duty nursing. 4. Income tax adjustment for short terms of hospital services. Miss Myers said that deficiencies in our present set-up have become more evident to us due to: nurses moving about from place to place; nurses seeking post-graduate clinical experience; the efficiency of some voluntary workers after short courses.

Miss Myers reported on the study of registration examinations and outlined what the Committee now suggests: 1. Qualifying examinations at the end of the preliminary course. This has already been started in some provinces. 2. In examinations, we must decide what we wish to test, knowledge or skill, and also we must decide who is to set these papers and evaluate them.

Another urgent matter contained in Miss Myers's report was the recognition of the place of the subsidiary worker, her preparation, licensing and control. She is now recognized as a necessary part in a properly integrated nursing service.

The national committee suggests for further study, three types of nurses: 1. The subsidiary or so-called practical nurse, with a six-months to one-year course. 2. The clinical or bedside nurse, taking a two to three-year course. 3. The specialist, administrator, or teacher, with a three to four-year course.

Miss Myers also mentioned in her report the successful refresher course held for instructors October last, and the lack of material for the special page in *The Canadian Nurse* under the Hospital and School of Nursing Section, which needs support from our provincial section.

Considerable discussion from the floor followed the reading of this report, particularly on the merits of the qualifying examination and the question of the three grades of nurses. Qualifying examinations were further discussed and, on the whole, were favoured and a motion carried that the Hospital and School of Nursing Section make a study of this subject and bring their report back to the next annual meeting.

In her report as convener of the Public Health Section, Miss Muriel Hunter summarized the activities of this section for the past year, reporting that three nurses had availed themselves of scholarships offered by the Provincial Department of Health and were now employed, but that still more nurses were needed in this field if they could be secured. A very stimulating refresher course was held in Saint John last April and attended by practically all the public health nurses in the province.

Mrs. M. O'Neal, convener of the General Nursing Section, drew attention to recommendations sent out from the National Section to the provinces during the year and also pointed out that the demand for nursing service still exceeds the supply and that some adjustment must be made so that the seriously ill may be cared for. The fact was stressed that members of the St. John Ambulance Nursing Division and of the Red Cross work their eight hours daily and assist in hospitals during the evening. She challenged the private duty group to uphold their part and to: help our hospitals; relieve the student body; help make patients more comfortable and satisfied; uphold the standard of our nursing profession.

In her report as convener of *The Canadian Nurse* Committee, Mrs. N. King urged that every registered nurse in the province subscribe to their nursing journal and that more articles for publication be submitted.

We were happy to have with us again, Miss M. Kerr, editor and business manager of *The Canadian Nurse*, who gave us a very enlightening picture of the responsibilities of an editor and the background of producing the magazine itself.

Reports from the various Chapters in the province were presented and all showed a busy and profitable year, with much war work being done by the members.

The following slate of officers were elected for the next biennium: president, Marion Myers; first vice-president, Reta Follis; second vice-president, Hilda Bartsch; past president, Sister Kerr; honourary secretary, B. M. Hadrill; section conveners: hospital and school of nursing, Maisie Miller; general nursing, Mrs. Mary O'Neal; public health, Muriel Hunter; legislation committee, Dorothy Parsons; *The Canadian Nurse* committee, Laura Henderson; councillors: Saint John, M. Murdoch; Moncton, A. J. MacMaster, Sister Anne de Parade; St. Stephen, M. McMullen; Woodstock, Mrs. N. King; Campbellton, Sister Kerr.

Miss MacMaster, in the name of the N.B. A.R.N., presented Sister Kerr, the retiring president, with a beautiful bouquet of American Beauty roses, expressing the appreciation of the Association as a whole for her splendid leadership and untiring devotion during the past four years. Sister Kerr expressed her thanks, saying how touched she was by the tribute paid her.

Following the close of the meeting, the visiting members were entertained at supper at the Victoria Public Hospital by the Fredericton Chapter.

ALMA F. LAW
Secretary-Registrar.

Health Education

There is a crying demand for health education all over Saskatchewan, it is stated in one section of the report of the Saskatchewan Health Services Survey Commission to the provincial government.

The report, recently released by the government-appointed commission headed by Dr. Henry E. Sigerist, professor of history of medicine at Johns Hopkins University in Baltimore, Md., is an outgrowth of the Saskatchewan government's pre-election promise "to set up a complete system of socialized health services with special emphasis on preventive medicine."

The demand for health education is an encouraging sign, the report says, "because it shows that the population is fully aware of the significance of health, and is receptive for instruction and advice. Health education obviously begins in the school, and to that end it may be necessary to revise the curriculum of the normal schools", the report says. The idea is not to make health officers of the school teachers but to draw their attention to physical and mental disease conditions that may develop in children, and to teach them how to develop sound health habits in their students. Through the children, the teacher may be able to educate the parents, and the teacher is the most powerful ally of the physician and nurse, in that he can draw their attention to certain children.

"In promoting health through education, all civic organizations such as Homemakers' clubs and the voluntary health organizations, etc., close co-operation with the organs of the physical fitness and recreation program and similar organizations".

The report recommended that the content of important health legislation should be brought to the attention of the people in pamphlets written in popular style. It had been found that people frequently were not informed about health legislation enacted for their benefit and that the language of such Acts was not always easy to understand.

—Health News Service.

A Correction

Through a mistake in information, the article on the General Nursing Page in the October issue of the *Journal* was credited to Miss Winnifred Ashplant instead of to Miss Dora Arnold of the Brantford General Hospital. Our apologies are tendered for this unintended error.

STUDENT NURSES PAGE

Nursing Care in Prolapse of Rectum

ETHEL M. WOODS

Student Nurse

Halifax Infirmary School of Nursing

A music teacher, forty-two years of age, was admitted to the hospital on March 7, 1944. Having been hospitalized on several previous occasions for various treatments, Miss R. was thoroughly familiar with her surroundings and proceeded to make herself at home. During the first few days she was able to be about her special interests were soon recognized — books, linen, embroidery floss and hoops were very much in evidence.

In 1939, Miss R. was treated for prolapse of the rectum, and her condition improved for some time. About three months ago, the old complaint again arose and with it a marked irregularity in menstrual periods, the flow increasing to severe bleeding accompanied by severe pain. For this condition ergotrate Tab. no. 1, t.i.d. was ordered with very good results. The prolapse was recognized as a difficult condition to cure, many operations and treatments having been used to no avail in similar cases. With a view to giving temporary relief rather than a permanent cure, the doctors decided upon an injection which would scarify the mucous membrane lining of the rectum making it adhere to the underlying tissues from which it had become detached, thus preventing this lining from slipping down through the rectum upon defecation.

Preparations had to be made as for an operation. After the prescribed soap-suds enema a large portion of the rectum protruded with the return flow of the solution and could be replaced only by the application of pressure applied by the patient herself. It was at this time that I first noted Miss R's nervousness about her condition which persisted until she was able to be up and around again. The perineal preparation was done on the evening of March 27. Nembutal gr. 1ss was given at bed time to assure a good night's rest. Nervousness and excitement interfered with the effects of the sedative and the next morning found Miss R. quite upset because the bowels had moved again with the usual protrusion. A hypodermic injection of morphia gr. 1/6 and atropine gr. 1/150 was given before she was taken to the operating room.

After placing the patient in a lateral position with head low and knees flexed, about 1.8 cc. pontocaine and glucose 10 per cent was introduced into the subarachnoid space as a spinal anesthetic. She was then turned on her back and placed in position for the rectal injection. This was a solution of phenol 5 per cent in oil, and was injected around the entire rectum, laterally and posteriorly, about 15 cc. being used. Vaseline was placed in the rectal ampulla and sterile dressings

protected the area of the injection. These were kept in place with a T-binder.

On returning to her room, Miss R. was kept flat on her back for the rest of the day to prevent the severe headache and dizziness which result from elevation of the head after a spinal anesthetic. During the afternoon, large amounts of whitish fluids were vomited. Pain necessitated the administration of morphia gr. 1/6. For four days Miss R. had to be catheterized, but on the evening of the fourth day she voided normally, with the aid of a very warm bedpan. From then on catheterization was not necessary.

All went well for a few days until, without any apparent reason, Miss R's temperature rose from normal to 102. Then followed nausea, vomiting and severe pain in the left kidney region. At night especially, the patient was most uncomfortable, awaking with great pain and bathed in perspiration. The doctor was notified and ordered a catheter specimen of urine to be analysed. The test showed the presence of numerous pus cells and clumps of pus. Sulfadiazine gr. viiss q. 4. h. was ordered for this and after four days the slight kidney infection had cleared up, leaving the urine normal. The pain did not return.

Great care had to be taken to prevent any movement of the bowels until the eighth day after the first injection The patient had no difficulty in turning from side to side. On the eighth day an olive oil enema was given. Here we had to guard against undoing the good work of the past week. The enema had to be given and expelled very slowly with the patient on her left side. This precaution was taken to prevent a possible forcing of the weak muscles of the rectum.

A very important consideration in the care of the patient was her diet. A non-residue diet was prescribed for a few days in order to prevent the possibility of a bowel movement. This diet included tea, coffee, broths, strained fruit juices, carbonated waters and gelatin desserts. Following this, such additions as arrowroot preparations, cream of wheat, eggs, butter, melba toast were allowed until after the tenth day when the gradual return to a general diet began. Mineral oil was also very important in the treatment. It was not, properly speaking, a cathartic, but it passed down the intestinal tract as an emulsion and thereby hindered the absorption of water in the colon. The consequent increased water content of the feces not only increased their bulk, but kept them soft.

Perhaps the hardest thing during the first few weeks was the problem of keeping Miss R. at rest. All stretching, all strain at defecation or voiding had to be prevented. Being a very quick and active person the patient had to keep constantly reminding herself of her present limitations. In the treatment, three injections of phenol 5 per cent in oil were used. Examinations of the rectum showed very encouraging results. Two months later she was able to be about and was quite convinced that the result of her treatments would bring permanent relief, although her doctor had made no promises nor built up hopes to that effect. She returned to her music pupils feeling better than she had felt for years.

Journals Wanted

The Manitoba Association of Registered Nurses has had a request from one of their members, now serving overseas, for a complete set of *The Canadian Nurse* for 1943 and from January to October 1944. Any reader of the *Journal* who could spare these copies is requested to notify Miss Margaret Street, Executive Secretary, Manitoba Association of Registered Nurses, 212 Balmoral St., Winnipeg.

Book Reviews

Mental Hygiene, A Manual for Teachers, by J. D. M. Griffin, M.D., S. R. Laycock, Ph.D., and W. Line, Ph.D. 291 pages. Published by the American Book Company. Canadian agents: W. J. Gage & Co. Ltd., 82 Spadina Ave., Toronto 2B. 1940. Price $2.20.

Reviewed by Clare Franckum, Reg. N., Medical Dept., Protestant School Board, Montreal.

In the foreword to this "Manual for Teachers" Dr. Clarence M. Hincks points out that there is a partnership between education and mental hygiene and that teachers and parents must be mental hygienists as well as educators. Many of the personal and social ills of our present-day civilization could have been prevented by more enlightened and understanding arrangements in our schools and homes.

The Canadian co-authors are well known in the fields of psychiatry, psychology and education. Their approach is from the teacher's point of view and they mention that their purpose has not been to encourage teachers to become mental hygiene specialists but to show that the mental hygiene point of view is compatible with and essential to good teaching and sound education. "The teacher and the educative process can make signal contributions toward the development of sound mental health and vigorous, wholesome personality."

The book is confined to problems in mental health related to the classroom. The following quotation summarizes the contents: "We have seen that the developing personality of the child is influenced for better or worse by a wide variety of factors. His inherent mental ability or lack of ability, his physical health or disability, the individual circumstances of his home, his community, his family, and his friends, and, finally, the organization, the administration, and the curriculum of his school — all these play a part in determining whether the child's basic needs are met satisfactorily and legitimately or not. All these factors, therefore, influence the development of his personality." Short case histories are given to illustrate the different types of behaviour problems. Emphasis is placed on seeking the cause of abnormal behaviour and suggestions are offered in dealing with each problem. There are numerous foot-notes and lists of reference literature.

Although written for teachers this book would be useful to parents, nurses, social workers or others interested in the development of wholesome personality in childhood.

Handbook of Nursing in Industry, by M. Gray Macdonald, R.N. 226 pages. Published by W. B. Saunders Company, Philadelphia & London. Canadian agents: McAinsh & Co. Limited, 388 Yonge St., Toronto 1. 1944. Price $3.00.

Reviewed by Jean Whiteford, Industrial Nurse, Winnipeg Air Observer School.

In giving this book to industrial nurses the author has provided some very valuable advice for their use. There is a warmth of understanding of human nature evident throughout that is very admirable—understanding of the employee's needs and viewpoint, knowledge of the employer-employee relations, and the industrial nurses' position in this relationship.

Emphasis is placed on the personality of the nurse in industry, and advice is given to those about to enter this field, outlining the demands on her tactfulness, "ability to like people, even if they are reeking of unpleasant odors", as well as how her responsibility for the health and welfare of the employee's family can assist production.

The growing demand for this service in the United States is shown by the statistics Miss Macdonald has given. There were twenty-four industrial nurses employees in 1909, and 11,220 in 1943. The importance of sickness and accident prevention with a full knowledge

of the workmen's compensation laws and the laws governing the state or province in which the nurse works is recommended.

There are some very good suggestions for setting up a health centre and the equipment required, as well as how they can be of most value to the staff. Samples of records from several different firms are shown at the back of this little book and would be most helpful and quite easily adapted to the industrial nurses needs.

The one criticism is that very little assistance is given the nurse who wishes advice on where to obtain further training and there is no emphasis placed on the value of public health training for the industrial nurse. This seems a weakness considering the demands that are made on the industrial nurse at the present time.

Nurse Please! pictured by Jean McConnell. Published by J. B. Lippincott Company; Canadian office: Medical Arts Building, Montreal 25. 1944. Price $1.50.

An amusing yet charming little brochure which depicts, pictorially, the heart-warming yet heart-rending experiences of "Susie" during the course of her training to be a nurse. You will enjoy her bewilderment, her fumbling and her successes because they are so typical of what every nurse has experienced, even down to the slip in technique which resulted in Susie developing measles. And do you remember the first time you tried to put a patient into a wheel-chair? Poor Susie! You will enjoy this book.

Concise Pharmacology and Therapeutics, by F. G. Hobart, Ph.C. and G. Melton, M.D., M.R.C.P. 168 pages. Published by Leonard Hill Ltd., London, England. 2nd Ed. 1944.

Reviewed by Catherine L. Townsend, Reg. N., Instructor, Teaching Dept., Montreal General Hospital.

This book is just what it claims to be—"A Concise Pharmacology and Therapeutics of the more important drugs, together with an introduction to the art of prescribing." While this is definitely not a "nursing text" it is a hand book that teachers of pharmacology, clinical supervisors, and head nurses will value. It deserves a place in the reference libraries of nursing schools.

To facilitate use, a list of the principal abbreviations used in the book is found before the table of contents, and this, plus the index at the end of the volume, will enable one to find information very readily.

Under the heading "Some Definitions" interesting facts are noted. To the instructor who has struggled with the metric and apothecaries' systems of weights and measures the following quotation will be of interest: "This book expresses the majority of doses and illustrates prescribing on the apothecaries' system. That it has not been found practicable to be wholly consistent in this matter is due to the fact that prescribers are in the early stages of a very slow transition from the apothecaries' system to the metric system . . . It is hardly necessary to stress how great is the need for caution while two such

From "Nurse Please!", courtesy of J. B. Lippincott Co.

widely different systems for expressing dosage are in simultaneous employment."

The standardization of drugs and their preparation is discussed briefly and simply — Digitalis, Insulin, Post-pituitary Extract, Vitamin D and Neoarsphenamine being used as illustrations. Although reference to proprietary medical products has been minimized, for convenient reference a list of proprietary names and non-proprietary equivalents is furnished.

The more important drugs are covered in the body of the text. Source, active principles, action, dosage, and method of administration are stated concisely. In the final chapter newer drugs which escaped mention in the appropriate section of the book are dealt with. Penicillin, Heparin, Dicoumarin, Thiouracil, and others of great significance today are among those mentioned.

The foreword by Sir Adolphe Abrahams pays tribute to the physician and the pharmacist whose co-operation made possible this valuable text.

Pediculosis Exclusions

Close nursing supervision and prompt action are keeping pediculosis exclusions to a new low mark in metropolitan public schools, according to a recent survey. A typical report came from Boston, where it was reported there are about eight thousand cases of head lice among school children annually. The total school enrolment is approximately one hundred and thirty five thousand. Cases of crab lice and body lice are rare. A majority of the head lice cases are in lower grades, with very few among high school students.

"Every child in the Boston school system is inspected for lice", the report from this city stated. "Students detected having lice are immediately sent home from school, after being presented with instructions for getting rid of the condition. The student must be passed on by a school doctor before being accepted back to classes".

Where infestation is discovered a newly-developed pyrethrum ointment known as A-200 is proving effective. The ointment was developed by the medical officer in charge of Washington, D.C. penal institutions working in collaboration with McKesson & Robbins, Inc. In the final stages of research on the ointment, controlled tests on eight thousand prisoners were conducted. Among one group of 1,504 cases treated not one required a second application, and no cases of skin irritations were reported.

Appealing factors of the new A-200 so far as school doctors and nurses are concerned is that it is easily applied at home, is highly effective in the eradication of parasites and their eggs or nits without any allergic manifestations, contains no poisonous substance, does not permanently stain the clothing and can be safely used on children.

—*McKesson & Robbins, Inc. New York.*

Hysterical Fever

Studies have been made of clinical cases where elevation of the temperature is due to the effect of the emotions, particularly fear, excitement and suspense, resulting in so-called "hysterical" fever. According to Louis Slatin in the *Modern Hospital* for September 1944, these effects should be borne in mind particularly when a patient is being admitted to hospital. He urges that a member of the family, capable of giving the essential details, should accompany the patient; that the admitting office staff minimize as much as possible the psychic trauma by their caution in discussing the illness in the patient's hearing; that, unless absolutely necessary, no admissions to the ward be made during visiting hours when the "questioning stares and open comments" may add to the mental anguish of the patient. He also suggests that posters be displayed reminding visitors of the importance of their own emotional calm, and insistence upon permitting only a reasonable number of persons to visit the patient.

Thermos Treatment in Frostbite

SISTER RAYMONDE DE MARIE

Jacques, a fair slightly-built six-year-old boy from Navan, strayed from his companions last November and was actually lost for five days in the woods near his home. A member of the staff of the local newspaper watched anxiously for any news of the lost child and, becoming restless after the search had continued so long without avail, determined to set out with her husband to look for him. Having formerly lived in the district, they knew the paths north of the highway where Jacques might have wandered and their long search was rewarded when three hours later they found the boy huddled near a big boulder, trying to keep warm and whimpering with hunger. The temperature had fallen below zero and the cold rain had chilled him through and through. His feet (in rubber boots) were frost-bitten and his hands were swollen three times their normal size.

On being admitted to the Ottawa General Hospital his temperature was subnormal and an intravenous of glucose and saline, together with drinks of cocoa, were administered; a heat cradle was placed over him, and continual gentle rubbing of his hands restored circulation. By the afternoon, his temperature registered 101°. The following treatment was then carried out: the patient's feet were well washed with alcohol and cotton pledgets were placed between the toes to prevent them from sticking together due to the swelling. His legs were elevated and kept in position by aid of sandbags and ice bags were placed to cover the feet and lower legs. A thick layer of cellucotton was placed over the ice bags and over that a layer of cellophane, then another layer of cellucotton and finally all was covered with rubber. This formed a kind of thermos and kept the ice from melting for more than seven hours and did not necessitate moving the feet for that length of time. This treatment was kept up for four days and when terminated it was found that only the toes were gangrenous. Sad though it was that the toes had to be removed by surgical intervention, the doctors feel that they would have had to amputate the feet completely if the thermos treatment had not been used. To prevent shock, plasma and transfusions were given. It is interesting to note that no chest condition was ever present even after such a long exposure to inclement weather.

Generous gifts from various organizations provided special nursing care throughout the time that Jacques was critically ill and required constant attention. Healing progressed slowly on account of the patient's poor physical condition but the application of red blood cells to the unsutured feet, followed by thermolite rays, proved very efficacious. By December, he suffered from ptosis of the feet and, from the instep down, there seemed to be no strength. Plaster casts were applied to cover the feet and legs to the knees and it took three weeks to obtain correction.

Jacques spoke very little to the nurses and visitors about his experience. For a long time would cry out in his sleep that he was afraid and only gradually became accustomed to his surroundings. On the removal of the casts, special felt shoes were provided and the child began to walk. In a week's time he had learned to walk quite well, minus the help of his toes, and on February 20 was discharged from the hospital.

Progress of Disabled Impeded by Thoughtless Civilians

Disabled soldiers being prepared for their return to civilian life are seriously hampered in their efforts to adjust themselves by the morbid curiosity and thoughtlessness of some civilians, according to Staff Sergeant Robert K. Yandell, who lost a leg in the World War and is now instructing amputation cases at Walter Reed General Hospital in Washington.

A leg amputee is taught how to camouflage his prosthesis by balancing exercises, special shoulder and arm movements in walking, placing his feet in certain positions when he sits down or rises, and by many other means which help to avoid drawing attention to his disability. All the hours spent in this practice are nullified if people embarrass the men by stares and prying questions. The Army Medical Department has appealed to the public for understanding and co-operation in this respect.

Office of the Surgeon General
Technical Information Division
Washington, D. C.

R.C.A.M.C. Nursing Service

The Director General of Medical Services (Army) announces the following promotions and changes which have taken place in the Military hospitals overseas and in Canada in the last few months:

Major (Prin. Matron) *Blanche Herman*, R.R.C. (Montreal General Hospital, 1925) is Principal Matron of the Canadian Nursing Service in the Mediterranean.

Major (Prin. Matron) *M. R. Shaffner*, R.R.C. (Toronto General Hospital, 1922) is Principal Matron of the Canadian Nursing Service in France and Belgium.

Major (Prin. Matron) *Helen G. Hewton*, A.R.R.C. (Montreal General Hospital, 1939) is Principal Matron of No. 1 Canadian General Hospital.

Major (Prin. Matron) *Nancy B. Kennedy-Reid*, R.R.C. (Montreal General Hospital, 1940) is Principal Matron of No. 23 Canadian General Hospital.

Major (Prin. Matron) *Ida Henderson*, A.R.R.C. (Montreal General Hospital, 1924) is Principal Matron of No. 13 Canadian General Hospital.

Acting Major (Acting Prin. Matron) *Grace Paterson*, A.R.R.C. (Toronto Western Hospital, 1932) is Principal Matron of No. 12 Canadian General Hospital.

Major (Prin. Matron) *Elva C. Honey*, R.R.C. (Winnipeg General Hospital, 1934) is Principal Matron of No. 14 Canadian General Hospital.

Acting Capt. (Acting Matron) *L. Shephard* (Montreal General Hospital, 1928) is Assistant Matron of No. 14 Canadian General Hospital.

Capt. (Matron) *Constance Winter* (Royal Victoria Hospital, 1927) is Assistant Matron of Basingstoke Neurological and Plastic Surgery Hospital.

Acting Capt. (Acting Matron) *Isobel E. Gillespie* (Royal Victoria Hospital, 1937) is Assistant Matron at No. 10 Candian General Hospital.

Capt. (Matron) *Margaret Kellough*, A.R.R.C. (Toronto General Hospital, 1927) is Matron of No. 5 Casualty Clearing Station.

Capt. (Matron) *Ruth E. Littlejohn* (Winnipeg General Hospital, 1936) is Assistant Matron of No. 15 Canadian General Hospital.

Acting Capt. (Acting Matron) *Helen Sirrs* (Toronto General Hospital, 1929) is Matron of No. 3 Casualty Clearing Station.

Acting Capt. (Acting Matron) *Hilda Carson* (Toronto General Hospital) is Assistant Matron of No. 24 Canadian General Hospital.

Capt. (Matron) *Hazel E. Johnstone* (Ottawa Civic Hospital, 1941) is Matron of Windsor Military Hospital, Windsor, N.S.

Acting Capt. (Acting Matron) *Ella Covey* (Toronto General Hospital, 1924) is Matron of No. 1 Canadian Hospital Ship.

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Acting Capt. (Acting Matron) *Jean McPherson* (Royal Victoria Hospital, Montreal, 1924) is Matron of No. 2 Canadian Hospital Ship.

British Columbia Public Health Nursing Service

The following are the staff appointments to and resignations from the Public Health Nursing Service, Provincial Board of Health:

Helen Carpenter, consultant in public health nursing, has resigned from the Provincial Board of Health to accept an appointment on the teaching staff of the University of Toronto School of Nursing. During the coming year Miss Carpenter will be on a Rockefeller Fellowship attending the Johns Hopkins School of Hygiene and Public Health.

Mrs. Isabel Foster (Vancouver General Hospital, University of B. C. public health nursing course, Johns Hopkins School of Hygiene and Public Health, public health administration course) has been appointed Consultant, Public Health Nursing. She will be serving in Revelstoke, Kamloops, the Okanagan Valley and East Kootenay areas.

Elisabeth Ochs (Edmonton General Hospital and University of B. C. public health nursing course) has been appointed senior nurse on the staff of the Cowichan Health Centre, Duncan.

Betty Plumer (Vancouver General Hospital and University of B. C. public health nursing course) has been appointed to the staff of the Okanagan Valley Health Unit. She will be serving in the Kelowna rural area.

Edith Newby (St. Paul's Hospital, Vancouver, and University of B. C. public health nursing course) has been appointed Kelowna City nurse on the staff of the Okanagan Valley Health Unit.

Eileen Hughes-Games (Vancouver General Hospital and University of Toronto public health nursing course) has been appointed public health nurse in Chilliwack.

Ada George (Regina General Hospital and University of Toronto public health nursing course) has been appointed public health nurse in Powell River.

Kathleen Read (St. Joseph's General Hospital, Victoria, and University of B. C. public health nursing course) has been appointed to the staff of the Peace River Health Unit. She will be located in Dawson Creek.

Kathleen Comerford (St. Joseph's General Hospital, Victoria, and University of B. C. public health nursing course) has been appointed to the staff of the Saanich Health Unit.

Mrs. Doris Brentzen (Hazelton General Hospital) has been appointed to the staff of the Cowichan Health Centre, Duncan.

Eleanor Graham has resigned from Powell River to continue post-graduate work at Chicago University. *Jennie Hocking* has resigned from the staff of the Saanich Health Centre to continue work with the Metropolitan Health Committee in Vancouver. *Ruth Corbould* has resigned from the Prince Rupert Health Unit. *Mrs. E. Hahn* has resigned from Rossland Public Health Nursing Service to return to Alberta. *Christina Browning* has resigned from the Cowichan Health Centre staff to be married.

Victorian Order of Nurses for Canada

The following are the staff appointments, transfers, and resignations from the Victorian Order of Nurses for Canada:

Gwenyth Grant and *Lois Skinner* have been re-appointed to the Toronto staff following leaves of absence to take the course in public health nursing.

The following nurses have been appointed

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to the Toronto staff: *Doris Fowler,* Toronto Western Hospital and certificate course in public health nursing, School of Nursing, University of Toronto; *Agnes Collver* (Brantford General Hospital and certificate course in public health nursing, School of Nursing, University of Toronto); *Helen Turner* (Toronto General Hospital and certificate course in public health nursing, School of Nursing, University of Toronto); *Barbara Shutz* (Toronto Western Hospital and certificate course in public health nursing, School of Nursing, University of Toroton); *Norlaine Burnett* (Toronto Western Hospital and certificate course in public health nursing, School of Nursing, University of Toronto); *Frances Boyd* (Toronto General Hospital and certificate course in public health nursing, School of Nursing, University of Toronto).

The following nurses have been appointed temporarily to the Toronto staff: *Barbara Linklater* (Hospital for Sick Children, Toronto); *Kathleen Death,* (Soldiers' Memorial Hospital, Orillia); *Mary Mercer,* previously on the Halifax staff, has been appointed to the Montreal staff.

Edith McLean (Royal Alexandra Hospital, Edmonton; B.Sc.N., University of Alberta) has been appointed to the Calgary staff.

Irene Martin and *Inez MacDougall* (Hotel Dieu Hospital, Cornwall, and course in public health nursing, McGill University) have been appointed to the Vancouver staff.

Jean Hill, B.A. (Royal Victoria Hospital and course in public health nursing, McGill University) has been appointed to the Sackville staff.

Louise Bardawill (St. Joseph's Hospital, London, Ontario, and course in public health nursing, University of Western Ontario), *Catharine M. Kelly* (Victoria Hospital, London; B.Sc.N., University of Western Ontario), and *Margaret Penty* (St. Joseph's Hospital, Sudbury, and course in public health nursing, University of Western Ontario) have been appointed to the London staff.

Nance Cuyler (University of Alberta Hospital, Edmonton; B.Sc.N., University of Alberta) has been appointed to the North York staff.

Evelyn Knowles (Ottawa Civic Hospital and certificate course in public health nursing, School of Nursing, University of Toronto) has been appointed to the Calgary staff.

Marion Whebby has been re-appointed to the Halifax staff following leave of absence to take the course in public health nursing.

Margaret Martin (Saint John General Hospital) has been appointed temporarily to the Saint John staff.

Gwendolyn Tutty (Victoria General Hospital, Halifax), has been appointed temporarily to the Halifax staff.

Lorna Warman, (Toronto East General Hospital) has been appointed temporarily to the East York staff.

Christine Charter, supervising nurse on the Toronto staff, has been transferred to the Vancouver staff to be assistant district superintendent.

The following nurses have resigned from the Toronto staff: *Margaret Mellon,* to accept a position with the Toronto Department of Health; *Grace Arnold,* to be married; *Phyllis Morrison,* to enter the R.C.A.F. Nursing Service; *Helen McRorie,* to accept a position with the Canadian Red Cross Nursing Service; *Marjorie Taylor, Lenore Wellar, Madeline Herbert, Marion Scott, Lucy Ashton* and *Lyle Fauteux* for other reasons.

The following nurses have resigned from the Montreal staff: *Adele McIvor,* to take up other work; *Ethel Wilsey,* to enter the R.C.A.M.C. Nursing Service; *Evelyn Johnston* (MacKinnon), because her husband was transferred.

Edna Harvey has resigned from the Lunenburg, N.S. branch to be nearer home.

Ruth Villeneuve has resigned from the Cornwall staff to be married.

Dorothy Chard has resigned from the East York staff to be nearer home.

Ada George has resigned from the North York staff to do other work.

Claire Rochez has resigned from the Ste. Anne de Bellevue Branch to accept a position with the Department of Health in Montreal.

Winnifred McQuaid has resigned from the Moncton staff to enter the R.C.A.F. Nursing Service.

Jane Hadley has resigned from the Halifax staff to be married.

Flora Macdonald is on leave of absence from the Burnaby Branch and is taking the course in public health supervision at McGill University.

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Helen McCarty has resigned from the Border Cities staff to take another position.

M.L.I.C. Nursing Service

Monette Gervais (St. François d'Assise Hospital, Quebec City) is now at the School of Public Health Nursing, University of Montreal, taking the public health nursing course. Miss Gervais has been granted a Company scholarship for this purpose.

Jeannette Coulombe (St. Sacrement Hospital, Quebec City) was recently transferred from the Montreal to the Quebec City nursing staff.

Madeleine Bulteau (St. Jeanne d'Arc Hospital, Montreal, and University of Montreal public health nursing course) and *Liane Chevalier* (St. Jean de Dieu Hospital, Gamelin, P.Q.) were recently appointed to the Metropolitan staff in Montreal.

Helene Talbot (Notre Dame Hospital, Montreal, and University of Montreal public health nursing course) recently resigned from the Metroplitan staff in Three Rivers.

Marie Anne Chess (Hotel Dieu de St. Joseph, Montreal, and University of Montreal public health nursing course) was recently transferred from the Quebec City nursing staff to Thetford Mines, P.Q.

Madeleine Cadieux (Sacred Heart Hospital, Hull, and University of Toronto public health nursing course) was recently transferred from Shawinigan Falls, P.Q. to the Montreal Nursing Staff.

Ina Dickie (Hamilton General Hospital and University of Western Ontario public health nursing course) was recently transferred from Fort William to Sudbury, Ontario, where she will be in charge of the Company's Group Nursing Service to employees of The International Nickel Company.

Aldea Campeau (St. Vincent de Paul Hospital, Sherbrooke, and University of Montreal public health nursing course) has been transferred from Sudbury to Shawinigan Falls, P. Q.

Josephine Hebert (Hotel Dieu Hospital, Montreal, and University of Montreal public health nursing course) was recently transferred from Thetford Mines, P.Q. to the Montreal Nursing Staff.

NEWS NOTES

ALBERTA

EDMONTON:

The Royal Alexandra Hospital Alumnae Association met recently with Miss Violet Chapman presiding. Plans were made for a dance, of which part of the proceeds will be used for "Ditty Bags". Dr. G. R. Davison, supervisor of tuberculosis work in this district, spoke on tuberculosis and the work of the mobile clinic. Eileen Piercy was awarded the Alumnae Scholarship and is now taking post-graduate work in obstetrics at the Vancouver General Hospital. Senior students were guests of the Association.

At a meeting held in November it was decided to hold a dance, the proceeds of which are to go to war charities. The convener is Edith Perkins. The president, who is also the provincial convener of *The Canadian Nurse* committee, reminded members of their responsibility and duty to the *Journal* in sending in articles and subscriptions. Dr. Irving R. Bell spoke on "Penicillin" and a social hour followed.

BRITISH COLUMBIA

VANCOUVER:

At the regular monthly meeting of the North Vancouver Chapter, R.N.A.B.C., Mrs. McDonald, the president, was in the chair. The guest speaker was Mrs. E. McMurray, who related her experiences in China and Japan as a missionary. She also told of her return trip on the *Gripsholm*.

The following officers were elected for 1944-45: president, Mrs. McDonald; vice-president, Miss Hallam; treasurer, Miss Jones; secretary, Miss Stenrud; program committee, Mrs. Johnston; social convener, Miss Cameron.

St. Paul's Hospital:

The 1943-44 session of St. Paul's Alumnae Association opened with tentative and enthusiastic plans for a busy and entertaining year. Outstanding members of the medical, technical, and nursing departments provided mental stimulation in their various talks.

Dr. M. Meekison regaled a large gathering with an account of "My experiences overseas". He gave a humorous account of his efforts to organize and open a new orthopedic unit, under English military supervision, and of the differences in methods of accomplishment in the two countries. Mr. R. D. Atkinson, laboratory technician,

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presented an instructive evening in the laboratory museum, displaying specimens and giving interesting data. Miss D. Vandenberg brought up-to-date knowledge on procedure and technique in the solution room. Miss D. Paton's talk on "Industrial Nursing" depicted a keen need in this field and concluded that often a kindly effort is required to assist in smoothing emotional difficulties of employees.

Graduate nurses from hospitals across Canada, on staff duty at St. Paul's, attended a social evening in November. Miss E. M. Palliser, superintendent of nurses at the Vancouver General Hospital, and Miss A. Wright, registrar of the R.N.A.B.C., were guests of honour.

Dr. W. F. Emmons donated a lovely doll's house for a raffle and many willing hands fashioned little furniture. The winner was Frances Reed, niece of Miss L. E. Otterbine. The financial return was most gratifying. Mrs. E. Thomson and Mrs. G. McGrenera promoted two Autumn and Spring rummage sales.

In March, the yearly event of the "Home-Coming" was held. This is essentially "the day when old friends meet". Each and every graduate is invited and Sister Columkille is the proud hostess. At this time we especially recall and wish for the presence of all our graduates, who are scattered far and wide.

The 1944 graduating class, totalling ninety-four, was entertained at dinner. Mrs. E. Faulkner, the president of the Alumnae Association, and Mrs. E. Thomson, former convener of the General Nursing Section, R.N.A.B.C., welcomed the class into the senior organization of their Hospital.

Lastly, and possibly the most important project of the season, is the work that has been done toward establishing a bursary for nurses. The Hospital staff doctors have generously and willingly consented to assist in this regard.

Fort George Chapter:

The Fort George Chapter, R.N.A.B.C., was formed and held its first meeting in April. The second meeting since the holidays was held in October at the home of the secretary, Mrs. Brolin. At this time the Chapter was glad to welcome four of the Nursing Sisters from the military hospital and it is hoped that they will be present often in increasing numbers.

After the business meeting, a report of the recent annual B. C. Hospital Convention was given by the president of the Chapter, Miss D. Saunders, who is matron of the City Hospital. Interesting highlights of the convention stimulated lively discussion following the address.

The entertainment committee organized a guessing contest and refreshments were later served.

NOVA SCOTIA

HALIFAX:

Miss Margaret Cameron, a graduate of St. Martha's Hospital, Antigonish, who has been on the staff of the Tuberculosis Hospital, Halifax, since 1925 resigned recently to take a position in Montreal. Since 1936 Miss Cameron has been assistant matron.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICT 5

TORONTO:

Women's College Hospital graduates from many parts of Canada and the United States, including the two first, Mrs. A. Buchanan of Windsor and Mrs. A. Buddah, of Toronto, attended the silver jubilee of the Alumnae Association held at the hospital recently.

Unveiling of a portrait of Mrs. Mary F. Bowman, Alumnae organizer and now its honourary president, and the presentation to her of twenty-five roses were highlights of the reunion dinner at Malloney's Galleries. Mrs. Buchanan spoke and Mrs. Carl C. Chisnell, Cayahoga, Ohio, also an early graduate, unveiled the portrait.

DISTRICT 8

At a recent meeting of District 8, R.N.A.O., held in Ottawa, Dr. T. L. Fisher, the guest speaker, gave a most enlightening talk on "The Legal Aspects of Nursing", which was most timely and very well received. The large attendance signified the increased interest in present-day problems and the eager desire to assist in their solution. On the invitation of the District, many student nurses attended the meeting.

Reports of standing committees were given by the following members: Rev. Sister Madeline, membership; hospital and school of nursing, W. Cooke; public health, H. Latimer. Miss Joan Stock reported on the C.N.A. convention held in Winnipeg and Miss E: Shiels reported on *The Canadian Nurse*. Miss Cooke also discussed the efforts of the committees on refresher courses,

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post-graduate work, and the history of nursing.

Ottawa General Hospital:

Viola Downie, Lois Kelly, Elizabeth Poulin, and Joan Stock are taking the public health nursing course at the University of Ottawa, and Miss Laure and Marguerite Bergeron are at the McGill School for Graduate Nurses. Sister St. Godefroy is now on the staff of St. Joseph's Hospital, Lowell, Mass., and Sister Emile de Marie is at St. Joseph's in Sudbury. Sister Georges Henri has been appointed supervisor of the obstetrical department of the O.G.H. and Sister Marthe du Sauveur is now director of the nursing service. Bernadette Legris has accepted the position of industrial nurse at the Dominion Rubber Company in Three Rivers. Albertine Lapointe has been appointed assistant night supervisor at the O. G. H.

PRINCE EDWARD ISLAND

The Charlottetown Hospital recently purchased the DeBlois property on Dundas Esplanade for the purpose of converting it into a nurses' home. At the annual meeting of the Alumnae Association the following officers were elected: president, Teresa O'Donell; first vice-president, Mrs. G. J. Maddigan; second vice-president, Florence McInnis; secretary, Minnie Lonnigan; treasurer, Dorothy Greenan.

Mrs. Doris MacDonald Millar, who has been serving with No. 7 Canadian General Hospital overseas for the past three years, is now on leave at her home in Souris. Mrs. Jack Dowling (Claire Clohossey) returned recently from Capetown, South Africa, where she has been on duty in Wynberg Military Hospital for two years. Mabel Grant, director of Red Cross work, has been replaced by Sophia Newsom, graduate of the Royal Victoria Hospital. Elizabeth Jenkins, graduate of P.E.I. Hospital, has accepted the position of instructor of nurses at the Aberdeen Hospital in New Glasgow.

QUEBEC

Montreal General Hospital:

At a recent meeting of the Alumnae Association Miss E. F. Upton and Miss M. Batson presented interesting reports of the C.N.A. biennial meeting. This is now the fourth season for our monthly Sunday teas, the proceeds of which are devoted to charitable purposes. Last month toys for British children were collected and about 150 toys and games were received and $75 in cash. An active sports program has been

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arranged this winter under the leadership of the surgical supervisor, Miss K. Clifford. This is principally for the student group but a few of the younger staff members have joined the basketball team.

Lieut.-Col. Dorothy MacRae, Matron-in-Chief, has been a guest of the Hospital while in Montreal attending to official duties.

The following Nursing Sisters have returned from duty overseas: G. C. Carter, E. A. MacQuisten, M. Paterson, G. A. Smeaton, and C. Cole, Mrs. J. Leishman (N/S G. Lake) has returned bringing her young son with her. N/S Anne Thorpe is among those appointed to the nursing staff of the hospital ship *Letitia*. Miss Thorpe has been on transport duty in Canada for some time.

G. Dwane has returned as a senior member of the night staff. M. Seybold and J. MacDougall have also joined the night staff. Audrey Skeete and Margaret Bowler have accepted positions on the operating-room staff. Mrs. J. Tait (Edith Little) has returned to the nursing staff after spending eighteen months with the R.C.A.M.C. overseas.

Royal Victoria Hospital:

Nursing Sisters Marguerite McDougall, Kathleen Scott, and Anne MacLeod have returned from overseas. Kathleen Cooke is assistant night supervisor in the Ross Pavilion. Dorothy Devlin is now in charge of Ward G, men's surgical. Helen Saunders is taking a further public health nursing course at Teachers College, Columbia University.

SASKATCHEWAN

A meeting of the Saskatchewan Hospital Association was held recently in Moose Jaw. At this meeting an enlightening dialogue entitled "Behind the Scenes", representing a day (and part of the night) in the life of a superintendent of nurses, was presented. This contained many subtle suggestions and was prepared by G. Motta, G. Giles, and Sister Eulalie. Those taking part were Dorothy Bradley, Ruth Reid, Alice Ralph, and Mrs. Alta Tait. At the hospital association meeting recommendations to serve as a basis for salaries, hours of duty and working conditions in hospitals were discussed and accepted. These were based on recommendations received from the C.N.A.

Rachael Resch, a graduate of the Regina General Hospital, and formerly president of the Regina Chapter of the S.R.N.A., has resigned this office in order to take up her duties as instructress of nurses at the Queen Victoria Hospital, Yorkton, Sask. Francine Philo, a graduate of the Regina Grey Nuns' Hospital, and formerly on the staff of that hospital, is at present taking a course in teaching and supervision at the University of Manitoba.

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Alberta: (1) Miss Ida Johnson, Royal Alexandra Hospital, Edmonton; (2) Miss B. J. von Gruenigen, Calgary General Hospital; (3) Miss R. E. McClure, Clover Bar Health Unit, Qu'Appelle Bldg., Edmonton; (4) Miss N. Sewallis, 9918-108th St., Edmonton.

British Columbia: (1) Miss G. M. Fairley, 3606 W. 33rd Ave., Vancouver; (2) Miss E. L. Nelson, Vancouver General Hospital; (3) Miss T. Hunter, 4238 W. 11th Ave., Vancouver; (4) Miss J. Gibson, 1035 W. 12th Ave., Vancouver.

Manitoba: (1) Miss L. E. Pettigrew, Winnipeg General Hospital; (2) Miss B. Seeman, Winnipeg General Hospital; (3) Miss L. Miller, 17 Lindall Apts., Winnipeg; (4) Miss J. Gordon, 3 Elaine Court, Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Miss M. Miller, 98 Wesley St., Moncton; (3) Miss M. Hunter, Dept. of Health, Fredericton; (4) Mrs. M. O'Neal, 170 Douglas Ave., Saint John.

Nova Scotia: (1) Miss R. MacDonald, City of Sydney Hospital; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss M. Shore, 314 Roy Bldg., Halifax; (4) Miss M. Ripley, 46 Dublin St., Halifax.

Ontario: (1) Miss Jean I. Masten, Hospital for Sick Children, Toronto; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss M. C. Livingston 114 Wellington St., Ottawa; (4) Mrs. F. Dahmer, 73 Patricia St., Kitchener.

Prince Edward Island: (1) Miss K. MacLennan, Provincial Sanatorium, Charlottetown; (2) Mrs. Lois MacDonald, Prince Co. Hospital, Summerside; (3) Mrs. C. H. Beer, 277 Kent St., Charlottetown; (4) Miss Mildred Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss Eileen Flanagan, 3901 University St., Montreal; (2) Miss Winnifred MacLean, Royal Victoria Hospital, Montreal; (3) Miss Ethel B. Cooke, 830 Richmond Sq., Montreal; (4) Mlle Anne-Marie Robert, 6716 rue Drolet, Montreal.

Saskatchewan: (1) Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; (2) Miss Ethel James, Saskatoon City Hospital; (3) Miss Mary E. Brown, 3 Bellevue Annex, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

Chairmen, National Sections: Hospital and School of Nursing: Miss Martha Batson, Montreal General Hospital. Public Health: Miss Helen McArthur, Provincial Health Department, Edmonton, Alta. General Nursing: Miss Pearl Brownell, 212 Balmoral St., Winnipeg, Man. Convener, Committee on Nursing Education: Miss E. K. Russell, 7 Queen's Park, Toronto, Ont.

General Secretary, Miss G. M. Hall, National Office, 1411 Crescent St., Montreal 25, P.Q

OFFICERS OF SECTIONS OF CANADIAN NURSES ASSOCIATION

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Councillors: Alberta: Miss B. J. von Gruenigen, Calgary General Hospital. British Columbia: Miss E. L. Nelson, Vancouver General Hospital. Manitoba: Miss B. Seeman, Winnipeg General Hospital. New Brunswick: Miss M. Miller, 98 Wesley St., Moncton. Nova Scotia: Sister Catherine Gerard, Halifax Infirmary. Ontario: Miss D. Arnold, Brantford General Hospital. Prince Edward Island Mrs. Lois MacDonald, Prince Co. Hospital, Summerside. Quebec: Miss Winnifred MacLean, Royal Victoria Hospital, Montreal. Saskatchewan: Miss Ethel James, Saskatoon City Hospital.

General Nursing Section

Chairman: Miss Pearl Brownell, 212 Balmoral St., Winnipeg, Man. First Vice-Chairman: Miss Helen Jolly, 3234 College Ave., Regina, Sask. Second Vice-Chairman: Miss Dorothy Parsons, 370 George St., Fredericton, N. B. Secretary-Treasurer, Miss Margaret E. Warren, 64 Niagara St., Winnipeg, Man.

Councillors: Alberta: Miss N. Sewallis, 9918-108 St., Edmonton. British Columbia: Miss J. Gibson, 1035 W. 12th Ave., Vancouver. Manitoba: Miss J. Gordon, 3 Elaine Court, Winnipeg. New Brunswick: Mrs. M. O'Neal, 170 Douglas Ave., Saint John. Nova Scotia: Miss M. Ripley, 46 Dublin St., Halifax. Ontario: Mrs. F. Dahmer, 73 Patricia St., Kitchener. Prince Edward Island: Miss Mildred Thompson, 20 Euston St., Charlottetown. Quebec: Mlle Anne-Marie Robert, 6716 rue Drolet, Montreal. Saskatchewan: Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon

Public Health Section

Chairman: Miss Helen McArthur, Provincial Health Department, Edmonton, Alta. Vice-Chairman: Miss Mildred I. Walker, Institute of Public Health, London, Ont. Secretary-Treasurer: Miss Jean S. Clark, City Hall, Calgary, Alta.

Councillors: Alberta: Miss R. E. McClure, Clover Bar Health Unit, Qu'Appelle Bldg., Edmonton. British Columbia: Miss T. Hunter, 4238 W. 11th Ave., Vancouver. Manitoba: Miss L. Miller, 17 Lindall Apts., Winnipeg. New Brunswick: Miss M. Hunter, Dept. of Health, Fredericton. Nova Scotia: Miss M. Shore, 314 Roy Bldg., Halifax. Ontario: Miss M. C. Livingston, 114 Wellington St., Ottawa. Prince Edward Island: Mrs. C. H. Beer, 277 Kent St., Charlottetown. Quebec: Miss Ethel B. Cooke, 830 Richmond Sq., Montreal. Saskatchewan: Miss M. E. Brown, 3 Bellevue Annex, Regina.

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

Pres., Miss Ida E. Johnson, Royal Alexandra Hospital, Edmonton; First Vice-Pres., Miss B. A. Beattie; Sec. Vice-Pres., Miss H. G. McArthur; *Councillor*, Sister A. Herman; Registrar, Miss Elizabeth Pearston, St. Stephen's College, Edmonton; Sec.-Treas., Miss Ruth M. Gavin, St. Stephen's College, Edmonton; *Chairmen of Sections*: *Hospital & School of Nursing*, Miss B. J. von Gruenigen, Calgary General Hospital; *Public Health*, Miss R. E. McClure, Clover Bar Health Unit, Qu'Appelle Bldg., Edmonton; *General Nursing*, Miss N. Sewallis, 9918-108th St., Edmonton; *Rep.* to *The Canadian Nurse*, Miss V. Chapman, Royal Alexandra Hospital, Edmonton.

Ponoka District, No. 2, Alberta Association of Registered Nurses

Chairman, Miss Mildred Nelson; Vice-Chairman, Miss Muriel Fuller; Secretary-Treasurer, Miss Ruth Parfett, Provincial Mental Hospital, Ponoka; *Representative* to *The Canadian Nurse*, Miss Frances Leek.

Calgary District, No. 3, Alberta Association of Registered Nurses

Chairman, Miss Kathleen Connor, Central Alberta Sanatorium; Vice-Chairman, Miss M. Deane-Freeman; Secretary, Miss Louise Thorne, 2208-50th Ave. S. E.; Treasurer, Miss Mary Watt; *Conveners of Sections*: *Hospital & School of Nursing*, Miss J. Connal; *Public Health*, Miss M. Pinchbeck; *General Nursing*, Miss G. Thorne.

Medicine Hat District, No. 4, Alberta Association of Registered Nurses

President, Mrs. Margaret Cove, Medicine Hat General Hospital; Vice-President, Miss Marjorie Middleton, 177 Third Street, Medicine Hat; Secretary-Treasurer, Mrs. Florence Eskestrand, 861 Third Street, Medicine Hat.

Edmonton District, No. 7, Alberta Association of Registered Nurses

Chairman, Miss Helen McArthur; First Vice-Chairman, Miss G. Bamforth; Sec. Vice-Chairman, Rev. Sr. Keegan; Sec., Miss R. Ball, 9903-111th St.; Treas., Miss I. Underdahl; *Committee Conveners*: *Program*, Miss M. Franco; *Membership*, Miss B. Emerson; *Reps.* to: *Local Council of Women*, Miss V. Chapman; *The Canadian Nurse*, Miss E. Matthewson.

Lethbridge District, No. 8, Alberta Association of Registered Nurses

Pres., Miss Anna Weeks, 706-7th Ave. S.; First Vice-Pres., Miss Agnes Short, Galt Hospital; Sec. Vice-Pres., Miss M. Bair, Galt Hospital; Secretary, Miss Gertrude A. Gow, 1210—3rd Ave. S.; Treas., Miss Mary Taylor, Nursing Mission.

BRITISH COLUMBIA

Registered Nurses Association of British Columbia

Pres., Miss G. M. Fairley, 3606 W. 33rd Ave., Vancouver; First Vice-Pres., Miss E. Mallory, 1086 W. 10th Ave., Vancouver; Sec. Vice-Pres., Miss E. Clark, Royal Columbian Hospital, New Westminster; Sec., Miss E. Paulson, 5792 Dunbar St., Vancouver; Registrar, Miss Alice L. Wright, 1014 Vancouver Block, Vancouver; *Councillors*: Misses E. Falliser, J. Jamieson, Mrs. E. Pringle, Sister Columkille; *Chairmen of Sections*: *Public Health*, Miss T. Hunter, 4238 W. 11th Ave., Vancouver; *General Nursing*, Miss J. Gibson, 1035 W. 12th Ave., Vancouver; *Hospital & School of Nursing*, Miss E. Nelson, Vancouver General Hospital; *Rep.* to *Press*, Miss Janie E. Jamieson, Vancouver General Hospital.

New Westminster Chapter, Registered Nurses Association of British Columbia

President, Miss Agnes Macphail; Vice-President, Mrs. Rutherford; Secretary, Mrs. G. Grieve; Treasurer, Miss V. Reeves.

Vancouver Island District

Victoria Chapter, Registered Nurses Association of British Columbia

Pres., Mrs. J. H. Russell; First Vice-Pres., Sr. M. Claire; Sec. Vice-Pres., Miss H. Latornell; Rec. Sec., Miss G. Wahl; Corr. Sec., Miss H. Unsworth, Royal Jubilee Hospital; Treas., Miss N. Knipe; *Conveners*: *General Nursing*, Miss K. Powell; *Hospital & School of Nursing*, Sr. M. Gregory; *Public Health*, Miss H. Kilpatrick; *Directory*, Mrs. G. Bothwell; *Finance*, Miss M. Dickson; *Membership*, Sr. M. Gabrielle; *Program*, Miss D. Calquhoun; *Publications*, Miss M. Laturnus; *Nominating*, Miss L. Fraser; *Corr. Delegate of Placement Bureau*, Mrs. Bothwell; *Registrar*, Miss E. Franks.

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Trail Chapter, Registered Nurses Association of British Columbia

President, Miss Dorothy E. Paulin, V.O.N., 968 Spokane Street, Trail; Secretary, Mrs. S. McKinnon, 901 Helena Street, Trail; Treasurer, Miss Mary Weir.

Okanagan District

Kamloops-Tranquille Chapter, Registered Nurses Association of British Columbia

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Greater Vancouver District

Vancouver Chapter, Registered Nurses Association of British Columbia

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MANITOBA

Manitoba Association of Registered Nurses

Pres., Miss L. E. Pettigrew, Winnipeg General Hospital; First Vice-Pres., Mrs. A. Savage; 745 Somerset Ave., Winnipeg; Sec. Vice-Pres., Mrs. D. L. Johnson, 341-13th St., Brandon; Third Vice-Pres., Rev. Sister Gettis, St. Boniface Hospital: *Board Members*: Miss E. Stocker, Ninette Sanatorium: Rev. Sister Marie Reine, St. Joseph's Hospital, Winnipeg; Miss J. Carruthers, 26 Wiltshire Apts., Winnipeg; Miss I. Barton, Deer Lodge Hospital, Winnipeg; Miss G. Spice, St. Boniface Hospital; Miss J. Whiteford, 93 Cordova St., Winnipeg; Miss I. Broadfoot, 7B Anvers Apts., Winnipeg; Mrs. A. Thierry, 74 Sherburn St., Winnipeg; *Section Chairmen*: *Hospital & School of Nursing*, Miss B. Seeman, Winnipeg General Hospital; *Public Health*, Miss L. Miller, 17 Lindall Apts., Winnipeg; *General Nursing*, Miss J. Gordon, 3 Elaine Court, Winnipeg; *Committee Conveners*: *Social*, Miss K. McLearn, Shriners' Hospital, Winnipeg; *Directory*, Mrs. A. Thierry, 74 Sherburn St., Winnipeg; *University of Man. Liaison*, Miss A. Carpenter, Winnipeg General Hospital; *The Canadian Nurse*, Mrs. F. Wilson, Winnipeg General Hospital; *Finance*, Miss W. Stevenson, 33 Gainsborough Apts., Winnipeg; *Press*, Miss F. Waugh, 214 Balmoral St., Winnipeg; *Visiting*, Miss F. Stratton, Winnipeg General Hospital; *Membership*, Miss M. Boyle, 160 Lansdowne Ave., Winnipeg; *Legislative*, Miss G. Spice, St. Boniface Hospital; *Instructors Group*, Miss G. Callin, Winnipeg General Hospital; *Reps. to: Local Council of Women*, Mrs. B. Moffatt, 1183 Dorchester Ave., Winnipeg; *Council of Social Agencies*, Miss L. Kelly, 753 Wolseley Ave., Winnipeg; *Junior Red Cross*, Miss J. Moody, 76 Walnut St., Winnipeg; *Canadian Youth Commission, Man. Co-operating Committee*, Miss D. Dick, 145 Montrose St., Winnipeg; *Directory Committee*, Miss A. McKee, 701 Medical Arts Bldg., Winnipeg; Miss R. Dickie, 103 Chestnut St., Winnipeg; Mrs. M. Reynolds, 20 Biltmore Apts., Winnipeg; Executive Secretary, Miss Margaret M. Street, 212 Balmoral St., Winnipeg.

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New Brunswick Association of Registered Nurses

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Registered Nurses Association of Nova Scotia

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ONTARIO

Registered Nurses Association of Ontario

Pres., Miss Jean I. Masten; First Vice-Pres., Miss M. B. Anderson; Sec. Vice-Pres., Miss G. Ross; Sec.-Treas., Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5; *Chairmen of Sections*: *Hospital & School of Nursing*, Miss D. Arnold, Brantford General Hospital; *Public Health*, Miss M. C. Livingston, 114 Wellington St., Ottawa; *General Nursing*, Mrs. F. Dahmer, 73 Patricia St., Kitchener; *Chairmen of Districts*: Miss M. Jones, Mrs. K. Cowie, Miss A. Scheifele, Miss P. Morrison, Mrs. E. Brackenridge, Miss E. Smith, Miss W. Cooke, Miss S. Laine, Miss M. Flanagan.

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Chairman, Mrs. K. Cowie; First Vice-Chairman, Miss D. Arnold; Sec. Vice-Chairman, Miss L. Kerr; Sec.-Treas., Miss M. Felpush, Kitchener & Waterloo Hospital, Kitchener; *Section Conveners*: *General Nursing*, Miss E. Clark; *Hospital & School of Nursing*, Miss G. Westbrook; *Public Health*, Miss M. Grieve; *Councillors*: *Brant*, Miss H. Cuff; *Dufferin*, Miss I. Shaw; *Grey*, Miss Wakefield; *Oxford*, Mrs. J. Sanders; *Huron*, Miss W. Dickson; *Bruce*, Miss H. Saunders; *Membership Convener*, Miss C. Attwood.

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District 6

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District 7

Chairman, Miss E. Smith; First Vice-Chairman, Miss L. Acton; Sec. Vice-Chairman, Miss I. Black; Third Vice-Chairman, Miss K. Walsh;

Sec.-Treas., Miss D. Morgan, Kingston General Hospital; *Councillors*: Misses E. Freeman, B. Griffin, E., Moffatt, M. Stewart, Mrs. M. Hamilton, Sr. St. Donovan; *Section Conveners*: *Hospital & School of Nursing*, Miss L. Acton; *General Nursing*, Misses L. Rogers, E. Sutton; *Public Health*, Miss I. Black; *Rep.* to *The Canadian Nurse*, Miss E. Sharp.

District 8

Chairman, Miss P. Walker; First Vice-Chairman, Rev. Sr. M. Evangeline; Sec. Vice-Chairman, Miss W. Cooke; Sec.-Treas., Miss J. Stock, 390 Chapel St., Ottawa; *Councillors*: Rev. Sr. Madeleine of Jesus, Misses I. Allan, V. Foran, K. McIlraith, M. McLachlan, H. O'Meara; *Section Conveners*: *Hospital & School of Nursing*, Miss W. Cooke; *Public Health*, Miss H. Latimer; *General Nursing*, Miss I. Dickson; *Pembroke Chapter*, Miss M. Young; *Cornwall Chapter*, Rev. Sr. Mooney; *Rep.* to *The Canadian Nurse*, Miss B. Jackson.

District 9

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District 10

Chairman, Miss M. Flanagan; Vice-Chairman, Miss M. Spidell; Sec.-Treas., Miss M. Beer, Isolation Hospital, Fort William; *Section Chairmen*: *Public Health*, Miss I. Dickie; *General Nursing*, Mrs. E. Geddes; *Hospital & School of Nursing*, Rev. Sr. Sheila; *Committee Conveners*: *Program*, Miss J. Hogarth; *Membership*, Miss M. Buss; *Councillors*: Misses E. McKinnon, M. Buss, O. Waterman, Sr. Sheila.

PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

Pres., Miss Katharine MacLennan, Provincial Sanatorium, Charlottetown; Vice-Pres., Miss Georgie Brown, Prince County Hospital, Summerside; Sec. Miss Helen Arsenault, Provincial Sanatorium, Charlottetown; Treas. & Registrar, Sister M. Magdalene, Charlottetown Hospital; *Chairmen of Sections*: *Hospital & School of Nursing*, Miss Anna Bennett, P.E.I. Hospital, Charlottetown; *General Nursing*, Miss Dorothy Greenan, 15 Grafton St., Charlottetown; *Public Health*, Miss Ruth Ross, Summerside.

QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated, 1920)

Pres. Miss Eileen C. Flanagan; Vice-Pres. (*English*), Miss Mary S. Mathewson; Vice-Pres. (*French*), Rev. Soeur Valérie de la Sagesse; Hon. Sec., Mlle Annonciade Martineau; Hon. Treas., Miss Mary Jeffrey Ritchie; *Members without Office*: Misses M. K. Holt, Marion Nash, Ethel Cooke, Rev. Sister Flavian, Rev. Soeur Mance Décary, Mlles Maria Roy, Jeanne Lamothe (Three Rivers), Anne-Marie Robert, Marguerite Taschereau (Quebec); *Advisory Board*: Misses Margaret L. Moag, Catherine M. Ferguson, Vera Graham, Mlles Maria Beaumier (Quebec), Juliette Trudel, Louise Taschereau; *Conveners of Sections*: *Hospital & School of Nursing* (*English*), Miss Winnifred MacLean, Royal Victoria Hospital, Montreal; *Hospital & School of Nursing* (*French*), Rev. Soeur Denise Lefebvre, Institut Marguerite Youville, Montreal; *Public Health Section* (*English*), Miss Ethel B. Cooke, Chandler Health Centre, 830 Richmond Sq., Montreal; *Public Health Section* (*French*), Mlle Marie E. Cantin, 4352 St. Denis, Apt. 3, Montreal; *General Nursing* (*English*), Miss Effie Killins, 3538 University St., Montreal; *General Nursing* (*French*), Mlle Anne-Marie Robert, 6716 Drolet St., Montreal; *Board of Examiners* (*English*): Miss Mary S. Mathewson (chairman), Misses Norena Mackenzie, Madeleine Flander, Elsie Alder, K. Stanton, Mrs. S. Townsend; (*French*): Rev. Soeur Marie Claire Rheault (chairman), Revs Srs. Paul du Sacré-Coeur, Marcellin, Jeanne de Lorraine, Mlles Juliette Trudel, Maria Beaumier; Executive Secretary, Registrar & Official School Visitor, Miss E. Frances Upton, Ste. 1012, Medical Arts Bldg., Montreal, 25.

SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

Pres., Miss M. R. Diederichs, Grey Nuns' Hospital, Regina; First Vice-Pres., Mrs. D. Harrison, 407 Cumberland Ave., Saskatoon; Sec. Vice-Pres., Rev. Sister Perpetua, St. Elizabeth's Hospital, Humboldt; *Councillors*: Rev. Sister Irene, Holy Family Hospital, Prince Albert; Miss M. E. Pierce, Barry Hotel, Saskatoon; *Chairmen of Sections*: *General Nursing*, Miss M. R. Chisholm, 803-7th Ave. N., Saskatoon; *Hospital & School of Nursing*, Miss E. James, Saskatoon City Hospital; *Public Health*, Miss M. E. Brown, 5 Bellevue Annex, Regina; Secretary-Treasurer, Registrar and Adviser, Schools for Nurses, Miss K. W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Regina Chapter, District 7, Saskatchewan Registered Nurses Association

Hon. Pres., Rev. Sr. Krause; Pres., Miss E. Worobetz; First Vice-Pres., Miss M. Nell; Sec. Vice-Pres., Miss H. Lusted; Sec.-Treas., Mrs. G. F. McNeill, 1840 Rose St.; Ass. Sec., Mrs. J. B. Thompson; Registrar, Mrs. G. F. McNeill; *Committees*: *Registry*, Miss M. Gillis; *Program*, Mrs. D. Weaver; *Membership*, Misses Earle, Chenier; *Finance*, Mrs. G. Deverelle; *War Service*, Mrs. Shannon; *Sick Nurses*, Miss M. Fleming, Mrs. G. Campbell; *Section Conveners*: *General Nursing*, Mrs. M. McBrayne; *Hospital & School of Nursing*, Mrs. Martin; *Public Health*, Miss R. Doull; *Rep.* to *The Canadian Nurse*, Miss D. Whitmore.

Alumnae Associations

ALBERTA

A.A., Calgary General Hospital, Calgary

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A.A., Holy Cross Hospital, Calgary

President, Mrs. Cyril Holloway; First Vice-President, Mrs. D. Overand; Second Vice-President, Miss L. Aiken; Recording Secretary, Mrs. B. McAdam; Corresponding Secretary, Mrs. J. E. Hood, 1811-15th St., West; Treasurer, Mrs. L. Dalgleish.

A.A., Edmonton General Hospital, Edmonton

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A.A., Misericordia Hospital, Edmonton

Hon. Pres., Rev. Sister Superior; Pres., Mrs. G. Stewart, Vice-Pres., Miss P. MacDonald; Sec., Miss A. Scott, 12219—128th St.; Treas., Miss D. Wood; *Committees*: *Social*, Mrs. Grant; *Press*, Miss B. Ramage; *Phoning*, Mmes Hough, Foster; *Visiting*, Mrs. Pike, Miss Foster.

A.A., Royal Alexandra Hospital, Edmonton

Hon. Pres., Miss M. S. Fraser; Pres., Miss V. Chapman; First Vice-Pres., Miss A. Anderson; Sec. Vice-Pres., Miss A. Lysne; Rec. Sec., Mrs. Furler; Corr. Sec., Miss L. Thomas, R.A.H.; Treas., Miss D. Watt.

A.A., University of Alberta Hospital, Edmonton

Pres., Miss A. Whybrow; Vice-Pres., Miss B. Pane; Rec. Sec., Miss D. Russell; Corr. Sec., Mrs. N. E. Alexander, 11045-83nd Ave.; Treas., Miss M. Baxter; *Social Committee*: Miss F. Beddome (convener), Misses I. Sloane, I Revell, Mrs. N. E. Pound; *Rep.* to *Press*, Mrs. N. E. Pound.

A.A., Lamont Public Hospital, Lamont

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BRITISH COLUMBIA

A.A., St. Paul's Hospital, Vancouver

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A.A., Vancouver General Hospital, Vancouver

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